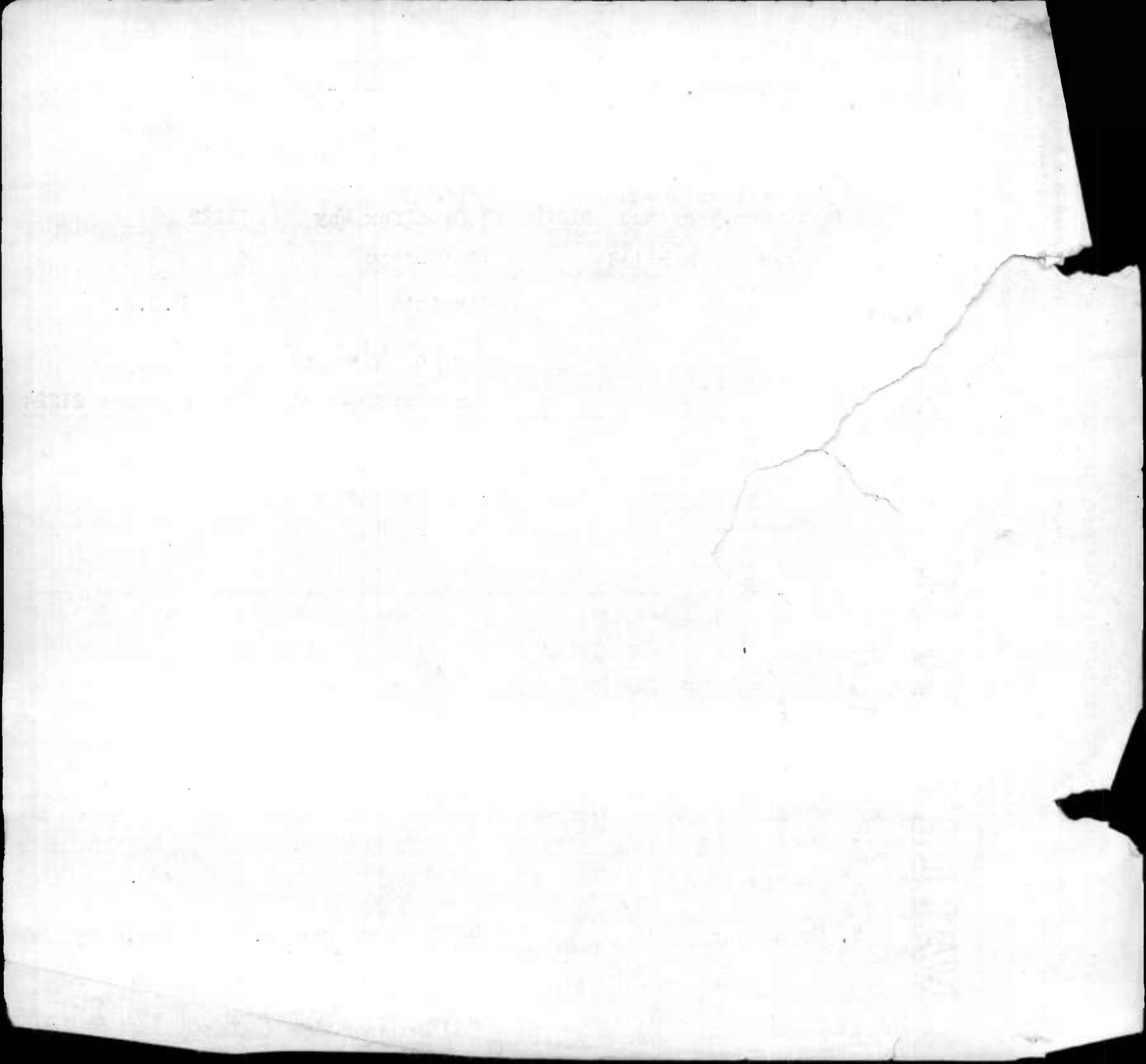


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00501		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 00501	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Geneva N. Johnson DUDLEY		2. DATE AND HOUR OF DEATH 1-14-1966 6A.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township) 3370 D. STREET ADDRESS (If rural, give location) 300 Colfax Way 21222			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12-18-1919	9. AGE (In years last birthday) 46	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Lula Wright		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Records: BCH-4940 Eastern Avenue 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Squamous cell Carcinoma of the esophagus; - metastatic -		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 2 years	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO			
19A. DATE OF OPERATION 04/9/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Insertion of Southern Tube		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/22/65 19 to 1/14/66 19 that (I) (we) last saw the deceased alive on 1/14/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE V. Hernandez		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/14/66	
23C. PHYSICIAN'S NAME (Type) V. Hernandez		23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-17-66		24C. NAME OF CEMETERY or CREMATORY Mount Calvary Cemetery	
24D. LOCATION A. A. Co. Maryland		24E. STATE (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JAN 17 1966		25B. NAME OF REGISTRAR R. B. E. J. Jones		25C. FUNERAL DIRECTOR The Mortimer & Dye II Fun'l	
25D. ADDRESS 1701 L...					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00502				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 00502	
1. NAME OF DECEASED (Type or Print) CARL FARMER				2. DATE AND HOUR OF DEATH 1-15-66 8:45AM M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1450 Montpelier Street					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7-7-94	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Buffer Silversmith			10B. KIND OF BUSINESS OR INDUSTRY Retired			11. BIRTHPLACE (State or foreign country) Knoxville Tenn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Farmer				14. MOTHER'S MAIDEN NAME Mary (Unknown)					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 225 03 1021		17. INFORMANT ADDRESS 1450 Montpelier Street Mrs Gertrude Farmer				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 15 min			
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Co. of lung		20A. AUTOPSY? (Yes or No) yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 1/7/66 19 to 1/15/66 19 that (1) (we) last saw the deceased alive on 1/15/66 19 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
23A. SIGNATURE J.R. SPENCER				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/15/66			
23C. PHYSICIAN'S NAME (Type) J.R. SPENCER				23D. ADDRESS JOHNS HOPKINS HOSP					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/18/66		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland			
25A. DATE REC'D BY HEALTH DEPT. JAN 17 1966		25B. NAME OF REGISTRAR P. E. F. F.		25C. FUNERAL DIRECTOR Henry Sander & Sons Inc.		ADDRESS Baltimore Maryland			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>66 00503</u>	
BIRTH NO. <u>66 00503</u>		1. NAME OF DECEASED (Type or Print) <u>Sula M. Redd</u>		2. DATE AND HOUR OF DEATH <u>Jan. 10/66 Am</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>1935 E. Safayette Ave</u>				A. STATE <u>BALTIMORE</u>			
				B. COUNTY <u>BALTIMORE</u>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>1935 E. Safayette Ave</u>			
5. SEX <u>F</u>	6. RACE <u>C</u>	7. MARRIED NEVER MARRIED WIDOWED DIVORCED (specify) <u>Married</u>		8. DATE OF BIRTH <u>Aug 3 1896</u>		9. AGE (In years last birthday) <u>69</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTH PLACE (State or foreign country) <u>Van</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Adams</u>				14. MOTHER'S MAIDEN NAME <u>Sillie Jones</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>213-14-8817</u>		17. INFORMANT <u>Family</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Coronary Artery Disease (Coronary Occlusion)</u>				CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden 1/10/66</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arterio Sclerotic Heart Disease complete years and Hypertension</u>				(B) DUE TO			
				(C) DUE TO			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>none</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>none</u>		20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>no</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>no</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>no</u>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>no</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>no</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>Nov 20 1963</u> to <u>Jan 10 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov 11 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Ralph J. Young</u>						23B. DATE SIGNED <u>11/13/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Ralph J. Young</u>				23D. ADDRESS <u>1532 E. Monument St Balto Md</u>			
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/14/66</u>		24C. NAME OF CEMETERY CREMATORY <u>Calvary Cemetery C.A.B. Md</u>		24D. LOCATION (City, town or county) (State) <u>Baltimore Md</u>	
25A. DATE REC'D BY HEALTH DEPT <u>JAN 17 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>		25C. NAME OF FUNERAL DIRECTOR <u>Robert Williams</u>		25D. ADDRESS <u>1701 N Bond St</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00504	
BIRTH NO. 66 00504				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) REV. JOSEPH M. SCANNELL			2. DATE AND HOUR OF DEATH 1-15-1966 6:15 A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION MERCY HOSPITAL			A. STATE Maryland B. COUNTY 27-12		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21212		
			D. STREET ADDRESS (If rural, give location) St. Mary's Church Rectory		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 2-4-1921	9. AGE (In years last birthday) 44	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Priest		10B. KIND OF BUSINESS OR INDUSTRY Religious	11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph M. Scannell			14. MOTHER'S MAIDEN NAME Mildred O'Hara		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS C. Raymond Scannell, 513 Hollen Road		
18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) CEREBRAL INFARCTION DUE TO (B) HYPERTENSIVE ENCEPHALOPATHY DUE TO (C) HYPERTENSIVE CARDIOVASC. DISEASE.			INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (s) (this hospital) attended the deceased from 12-17- 19 65 to 1-15- 19 66 , that (s) (we) last saw the deceased alive on 1-15- 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph Notarangelo M.D.				23B. DATE SIGNED 1-15-1966	
23C. PHYSICIAN'S NAME (Type) JOSEPH NOTARANGELO M.D.				23D. ADDRESS MERCY HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/18/1966		24C. NAME of CEMETERY or CREMATORY New Cathedral	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 17 1966			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.			

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

Registered No.

66 00505

BIRTH NO.

66 00505

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

GEORGE

Mr. Milton BAUM

2. DATE AND HOUR OF DEATH

JAN. 14, 1966 9:08 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

21214

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

27-04

D. STREET ADDRESS (If rural, give location)

2828 BEECHLAND AVE

5. SEX

MALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

Nov 15, 1881

9. AGE (In years
last birthday)

84

If Under 1 Yr.

Months: Days

(If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)UPHOLSTERER
RETIRED UNK

10B. KIND OF BUSINESS OR INDUSTRY

AUTO

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

SAMUEL BAUM

14. MOTHER'S MAIDEN NAME

Elizabeth Lippy

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

UNK

16. SOCIAL
SECURITY NO.

218-44-4679

17. INFORMANT

MRS. EDNA R. BAUM

ADDRESS

(SAME)

18. 430.01-133.3
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

UREMIA

(B) DUE TO

CHRONIC RENAL DISEASE

(C) DUE TO

GENERALIZED ARTERIOSCLEROSIS

INTERVAL BETWEEN
ONSET AND DEATH

2 wks

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.PNEUMONITIS, CHRONIC LUNG DISEASE, BENIGN GASTRIC ULCER,
CARCINOMA OF SIGMOID COLON, PARKINSON DISEASE

19A. DATE OF OPERATION

DEC 22, 1965

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED

GASTRIC ULCER, CA. OF SIGMOID

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner) ☐ NO21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~the~~ (this hospital) attended the deceased from DEC 10, 1965 to JAN 14, 1966.
that ~~the~~ (we) lost saw the deceased alive on JAN 14, 1966 and that in ~~my~~ (our) opinion death occurred on the date
and hour and from the causes stated above. (I) ~~the~~ (did) ~~did not~~ view the body after death.

23A. SIGNATURE

Wm Gregory Bruce

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

Jan 14, 1966

23C. PHYSICIAN'S
NAME (Type)

Wm. Gregory Bruce

M.D.

23D. ADDRESS

Mercy Hospital

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1/17/1966

24C. NAME of CEMETERY or CREMATORY

Moreland Memorial Park Parkville, Balto. Co., Md.

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 17 1966

25B. NAME OF REGISTRAR

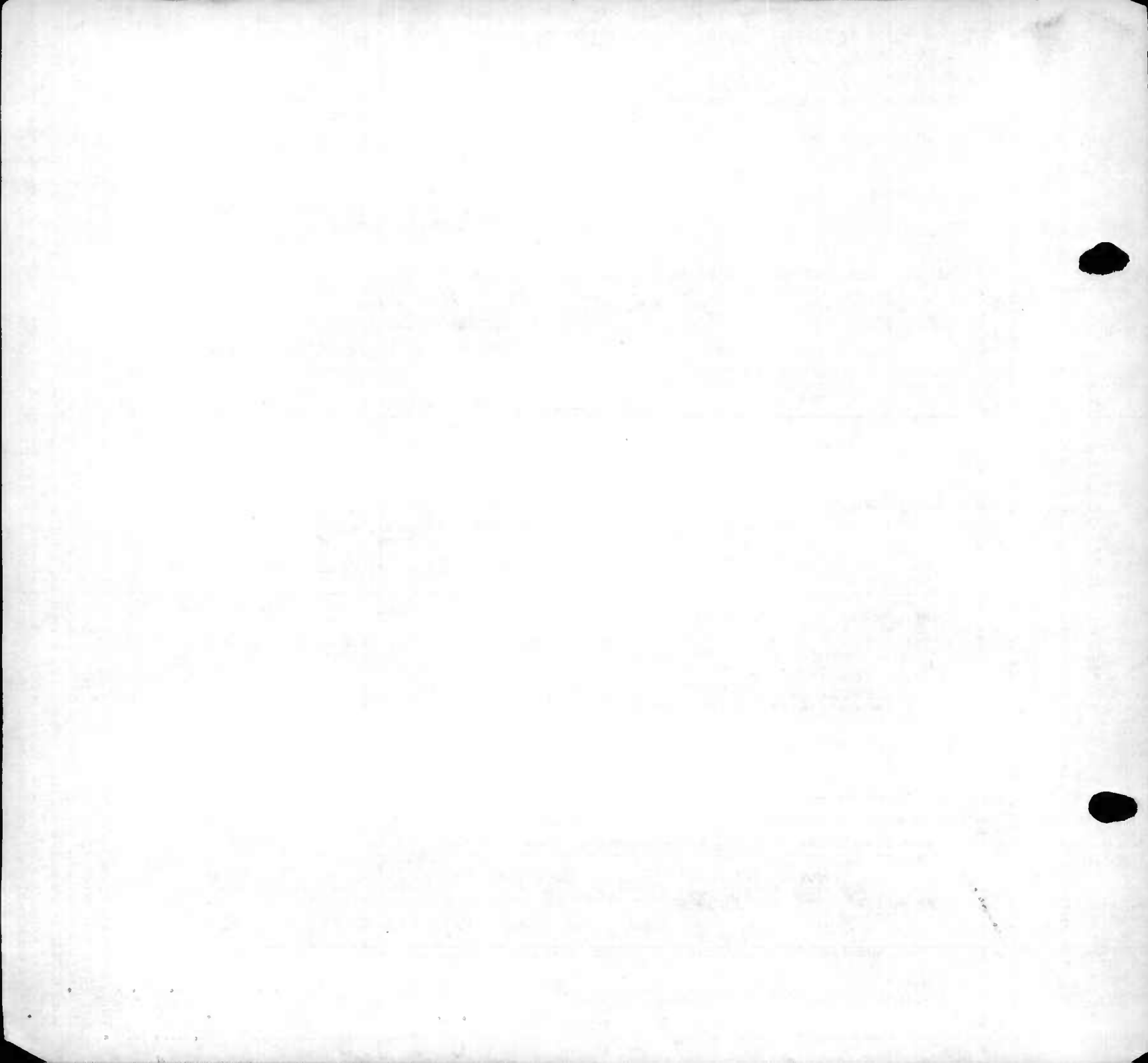
P. J. J. Jenkins

25C. FUNERAL DIRECTOR

H.W. Jenkins & Sons Co. 4905 York Rd.

ADDRESS

Balto. 12, Md.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

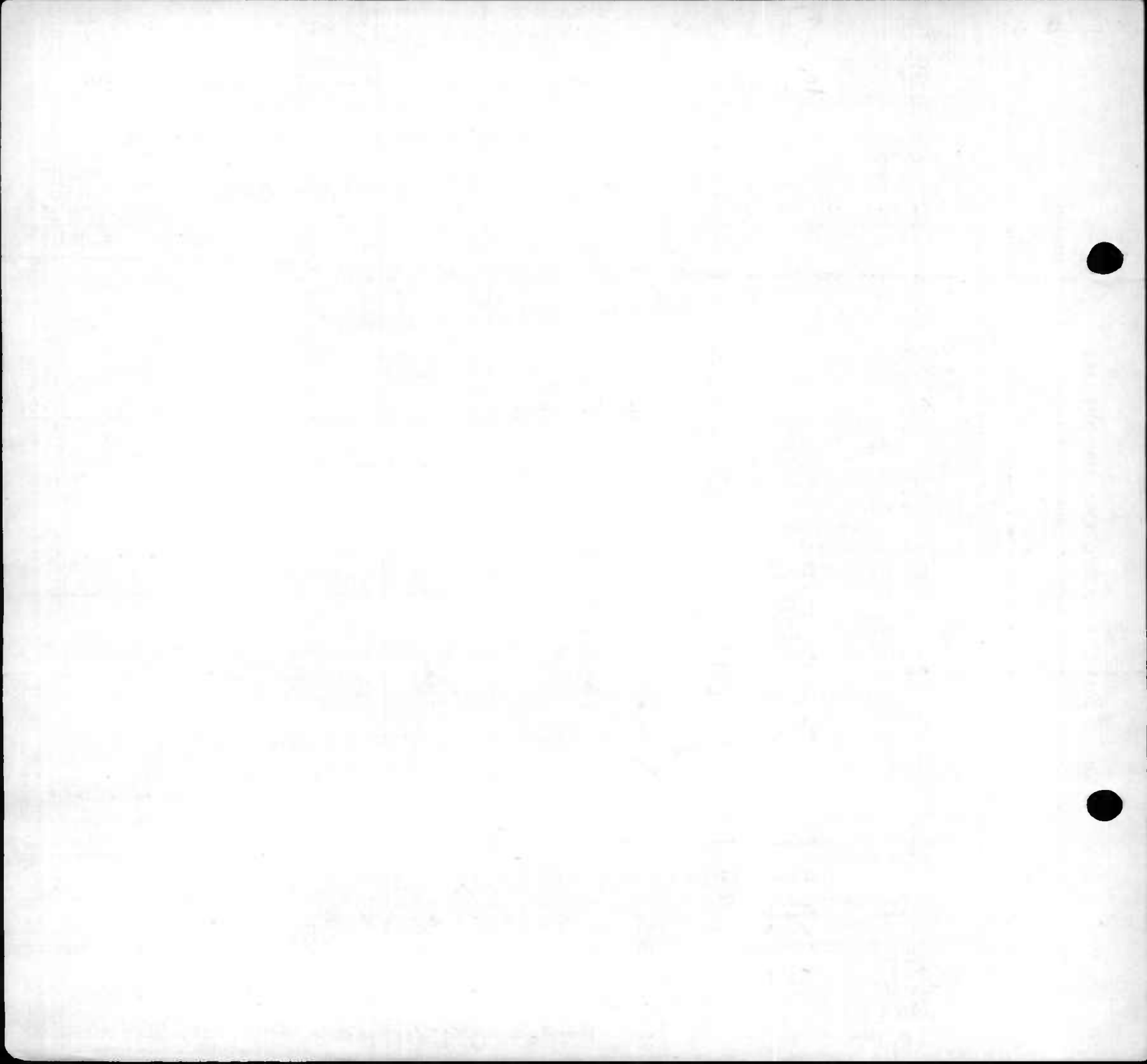
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00507	
BIRTH NO. 66 00507		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Margaret C. Gutting		2. DATE AND HOUR OF DEATH Jan. 14, 1966 11:30 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 6210 Blackburn Lane		D. STREET ADDRESS (If rural, give location) 6210 Blackburn Lane		27-12	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3-20-1890	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Canton, Ohio	
13. FATHER'S NAME Leonard E. Cooper		14. MOTHER'S MAIDEN NAME Ann E. Burke		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Lawrence F. Gutting	
				ADDRESS Same	
18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
		(A) Myocardial infarction		minutes	
		(B) arteriosclerotic heart disease		10+ yrs	
		(C) Arterial hypertension		25+ yrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Branchial asthma		10 years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Mar 7, 1946 to Jan 14, 1966, that (I) (we) last saw the deceased alive on Dec 17, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Frederick J. Vollmer		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1-15-66	
23C. PHYSICIAN'S NAME (Type) Dr. Frederick J. Vollmer		23D. ADDRESS 6100 York Road Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 1-17-66	24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Parkville, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 17 1966		25B. NAME OF REGISTRAR H. V. Jenkins & Sons Co.		25C. FUNERAL DIRECTOR ADDRESS 54905 York Road Balto., Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00508	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 66 00508 CERTIFICATE OF DEATH </div>					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) EMMALINE KRESS			2. DATE AND HOUR OF DEATH 1-15-66 10 AM M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital			A. STATE MARYLAND B. COUNTY BALTIMORE		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 26-01		
			D. STREET ADDRESS (If rural, give location) 4218 BAYONNE AVENUE 6		
5. SEX FEMALE	6. RACE CAU.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 7-24-1909	9. AGE (In years last birthday) 36	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME			10B. KIND OF BUSINESS OR INDUSTRY NONE		
11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND			12. CITIZEN OF WHAT COUNTRY? U. S. A		
13. FATHER'S NAME EDWARD KRESS			14. MOTHER'S MAIDEN NAME EMMA HELLDORFER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 218-28-0066		17. INFORMANT ADDRESS GEORGE K. KRESS 9644 BELAIR Road
18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Hypertensive Heart Disease			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
INTERVAL BETWEEN ONSET AND DEATH 1 year					
II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept. 10 1963 to Jan 15 1966 , that (I) (we) last saw the deceased alive on Jan. 13 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Adam E. Swiss				23B. DATE SIGNED Jan. 17, 1966	
23C. PHYSICIAN'S NAME (Type) ADAM E. SWISS				23D. ADDRESS 6232 BELAIR ROAD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-18-66		24C. NAME OF CEMETERY or CREMATORY BALTIMORE CEMETERY	
24D. LOCATION (City, town, or county) (State) NORTH AVENUE MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. JAN 17 1966		25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR ADDRESS DEPPEL BROTHERS INC. 7110 BELAIR Rd.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

Registered No. 66-00509

BIRTH NO. 66 00509		CERTIFICATE OF DEATH		Registered No. 70509	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Salvatore J. Pilo		2. DATE AND HOUR OF DEATH Jan. 16 - 66 5:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Md. B. COUNTY 3-02		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto.	
FULL NAME OF HOSPITAL OR INSTITUTION 0 411 S. Central Ave		D. STREET ADDRESS (If rural, give location) 411 S. Central Ave			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH April 7 1914	9. AGE (In years lost birthday) 51	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Balto. City		11. BIRTHPLACE (State or foreign country) Balto.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Anthony Pilo		14. MOTHER'S MAIDEN NAME Lidy Davague		ADDRESS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-09-5565		17. INFORMANT Anthony P. Pilo 4119 Beachwood Rd. 12	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenea, etc. It means the disease, injury or complication which caused death.) 13-6-1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH (A) DUE TO acute cardiac dilatation (B) DUE TO Carcinoma of liver (C)		INTERVAL BETWEEN ONSET AND DEATH 4 days 10/1/65	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II					
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20C. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/1/65 to 1/16/66 that (I) (we) last saw the deceased alive on 1/16/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S.C. Feldman		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/12/66	
23C. PHYSICIAN'S NAME (Type) S.C. Feldman		23D. ADDRESS M.D. 1440 G Balto. 12			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JAN 18 1966		24C. NAME of CEMETERY or CREMATORY HOLY REDOUBT CEMETERY	
24D. LOCATION (City, town, or county) (State) BALTIMORE MD		24E. NAME of REGISTRAR P.C. E. Feldman		24F. FUNERAL DIRECTOR B. J. B. due 1800 E LOMBARD ST	

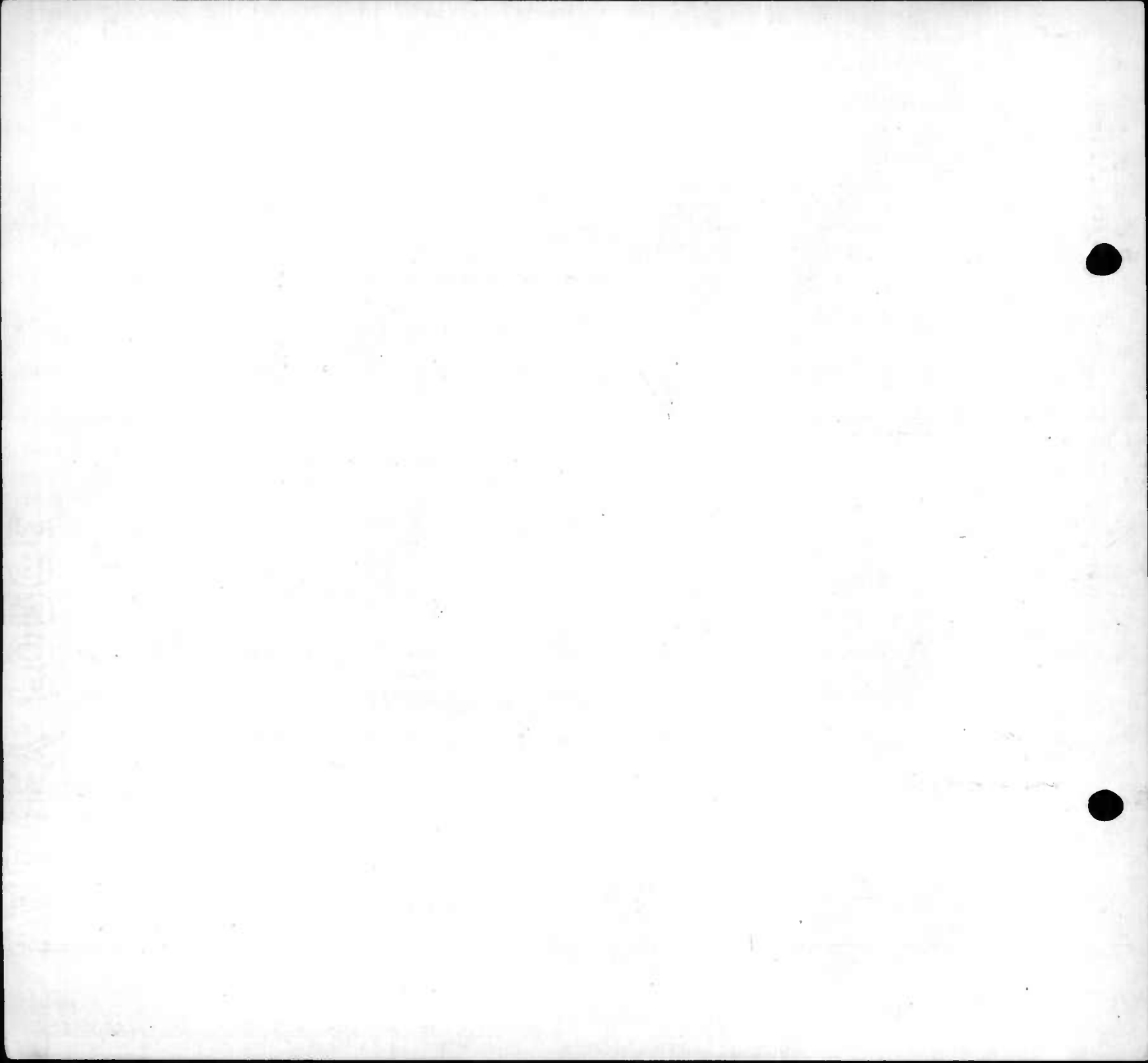
Handwritten text, mostly illegible due to fading. Some words like "The" and "and" are visible.

Handwritten text at the bottom of the page, possibly a signature or date, also illegible.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

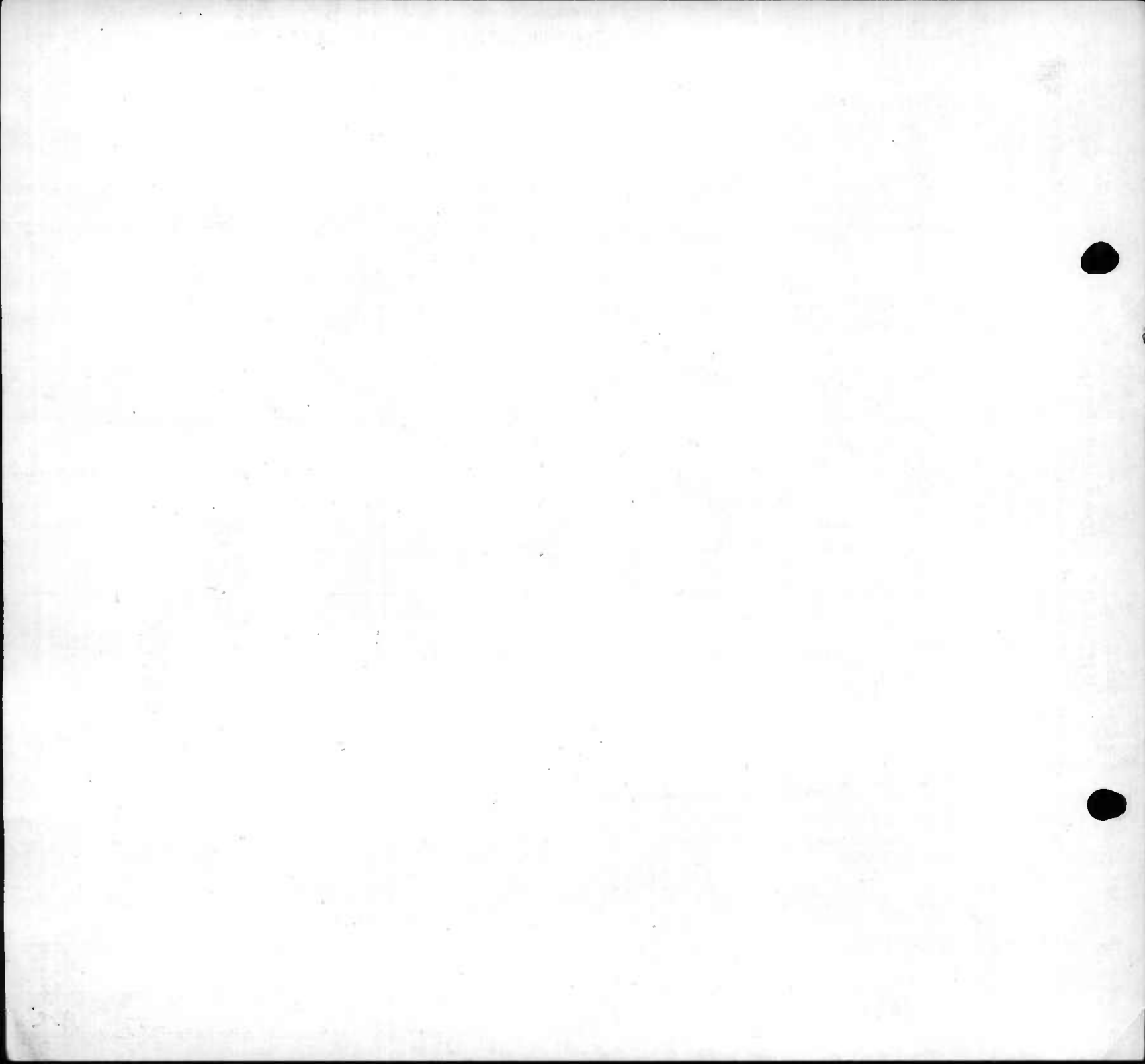
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00510	
BIRTH NO. 66 00510				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Bowers, James</i>				1/16/66 3:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <i>THE JOHNS HOPKINS HOSPITAL</i> 601 N BROADWAY 21205				A. STATE <i>BALTIMORE</i> B. COUNTY <i>9-05</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>MARYLAND</i> D. STREET ADDRESS (If rural, give location) <i>1413 CARSWELL STREET</i>	
5. SEX <i>MALE</i>	6. RACE <i>NEGRO</i>	7. MARRIED, NEVER MARRIED <i>MARRIED</i>	8. DATE OF BIRTH <i>8/15/33</i>	9. AGE (In years lost birthday) <i>32</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <i>JAMES BOWERS SR.</i>		14. MOTHER'S MAIDEN NAME <i>THOMPSON, INEZ</i>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <i>411X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Acute Pulmonary Edema</i> <i>Rheumatic valvular disease</i> CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) <i>Aortic Insufficiency</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 hrs.</i> <i>- 20 yrs.</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1/15</i> 19 <i>66</i> to <i>1/16</i> 19 <i>66</i> , that (I) (we) lost saw the deceased alive on <i>1/16</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) did (did not) view the body after death.					
23A. SIGNATURE <i>E. Eugene Page Jr.</i>				23B. DATE SIGNED <i>1/16/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>E. EUGENE PAGE</i>				23D. ADDRESS <i>601 N BROADWAY 21205</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>1-17-66</i>		24C. NAME OF CEMETERY OR CREMATORY <i>MT. CALVARY CEM.</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 17 1966</i>			
25B. NAME OF REGISTRAR <i>Robert E. ...</i>		25C. FUNERAL DIRECTOR ADDRESS <i>E. S. ... 1000 Brantley Ave.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				M.E. CASE NO.				55 78 80			
1. NAME OF DECEASED (Type or Print)				66 00511				CERTIFICATE OF DEATH			
2. DATE AND HOUR OF DEATH				January 15, 1966				12:55 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				Jeffries, Lafayette				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION				(If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Johns Hopkins Hospital				Maryland, Baltimore				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
1813 Rutland Avenue				Baltimore				D. STREET ADDRESS (If rural, give location)			
5. SEX				6. RACE				7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)			
Male				Negro				Married			
8. DATE OF BIRTH				9. AGE (In years last birthday)				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
3-31-98				67				Cowhide cutter			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME			
Virginia				US				Not known			
14. MOTHER'S MAIDEN NAME				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
Not known				Unknown				17. INFORMANT ADDRESS			
Wife				Same				18. CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				INTERVAL BETWEEN ONSET AND DEATH			
(A) Shock, pulmonary edema				2 hours				(B) Probable myocardial infarction			
(B) Arteriosclerotic CV disease				Years				(C) Multiple cerebrovascular accidents			
MEDICAL CERTIFICATION				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				19A. DATE OF OPERATION			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from January 7, 1966 to January 15, 1966, that (I) (we) last saw the deceased alive on January 15, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE				23B. DATE SIGNED			
Edgar W. Hull				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				January 15, 1966			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS				24A. BURIAL CREMATION, REMOVAL (Specify)			
Edgar W. Hull				Johns Hopkins Hospital				Burial			
24B. DATE				24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
1-19-66				Cancer Mem. Cem.				Laurel, Md.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR ADDRESS			
JAN 17 1966				Robert E. Johnson				F. J. Wilson 1000 Brimley Ave.			



66 00512

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 00512

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)Joseph
CARL STOLL

2. DATE AND HOUR PRONOUNCED DEAD

January 11, 1966 1:25 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Church Home and Hospital DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

106 N. Bradford Street

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

April 24, 1893

9. AGE (In years
last birthday)

72

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Perry Point

11. BIRTHPLACE (State or foreign country)

Helena, Montana

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Louis Stoll

14. MOTHER'S MAIDEN NAME

Emma L. Kroener

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

World War I

16. SOCIAL
SECURITY NO.

17. INFORMANT

Mrs. J. J. Walker

ADDRESS

12222 - 2nd Avenue, N. W.
Seattle, Washington

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Hypertensive cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Fibrinous pericarditis
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-12-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

23B. DATE

1/18/1966

23C. NAME of CEMETERY or CREMATORY

Arlington National Cemetary, Arlington, Virginia

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

JAN 17 1966

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Baltimore, Md.
North Ave.

WALLLEY POLICE

PLATE NO. 1

1961

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00513	
BIRTH NO. 66 00513		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WEBSTER, HARRY G.		2. DATE AND HOUR OF DEATH 1/14/66 12¹⁰ a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSP.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 21212 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4618 YORK ROAD			
5. SEX M	6. RACE CAUC.	7. MARRIED NEVER MARRIED WIDOWED DIVORCED (specify)	8. DATE OF BIRTH 6/11/81	9. AGE (In years last birthday) 84	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handy Man		10B. KIND OF BUSINESS OR INDUSTRY Gault Monument Company		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME WEBSTER, LUTHER		14. MOTHER'S MAIDEN NAME BLOOM, Mary C.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No		16. SOCIAL SECURITY NO. 214-14-0412		17. INFORMANT CHART	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) RESPIRATORY PROBLEMS DUE TO TO CORONARY VASCULAR ACCIDENT		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS	
18. II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. BLEEDING DUODENAL ULCER		(B) DUE TO			
		(C) DUE TO		GENERALIZED ARTERIO SCLEROSIS	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 1/7/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED G-I BLEEDING		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/5/66 19 to 1/14 19 66 , that (I) (we) lost saw the deceased alive on 1/14 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE J. D. Weiner				23B. DATE SIGNED 1/14/66	
23C. PHYSICIAN'S NAME (Type) DR. DESIRE W. VANDERHOEVEN		23D. ADDRESS UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 1/17/1966	24C. NAME OF CEMETERY or CREMATORY Springfield Cemetery		24D. LOCATION (City, town, or county) (State) Sykesville, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 17 1966		25B. NAME OF REGISTRAR Robert E. Taber		25C. FUNERAL DIRECTOR Wm. J. Taber & Son	

THE JOURNAL OF THE

AMERICAN MEDICAL ASSOCIATION

— — — — —

BIRTH NO.

66 00514

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 00514

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CLARENCE SHOTZBERGER

2. DATE AND HOUR PRONOUNCED DEAD

15 January 1966 4:30 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

819 N. Eutaw St.

21201

5. SEX

male

6. RACE

caucasian

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

March 19, 1917

9. AGE (In years
last birthday)

48

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Short Order Cook

10B. KIND OF BUSINESS OR INDUSTRY

Coney Island Grill

11. BIRTHPLACE (State or foreign country)

Burham, Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

World War II

16. SOCIAL
SECURITY NO.

188-07-1546

17. INFORMANT

ADDRESS

Mrs. Augustine Shotzberger same address

18. 420.0 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Fatty cirrhosis

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, steel, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/15/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Cremation

23B. DATE

1/15/1966

23C. NAME of CEMETERY or CREMATORY

Loudon Park Crematory

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JAN 17 1966

24B. NAME OF REGISTRAR

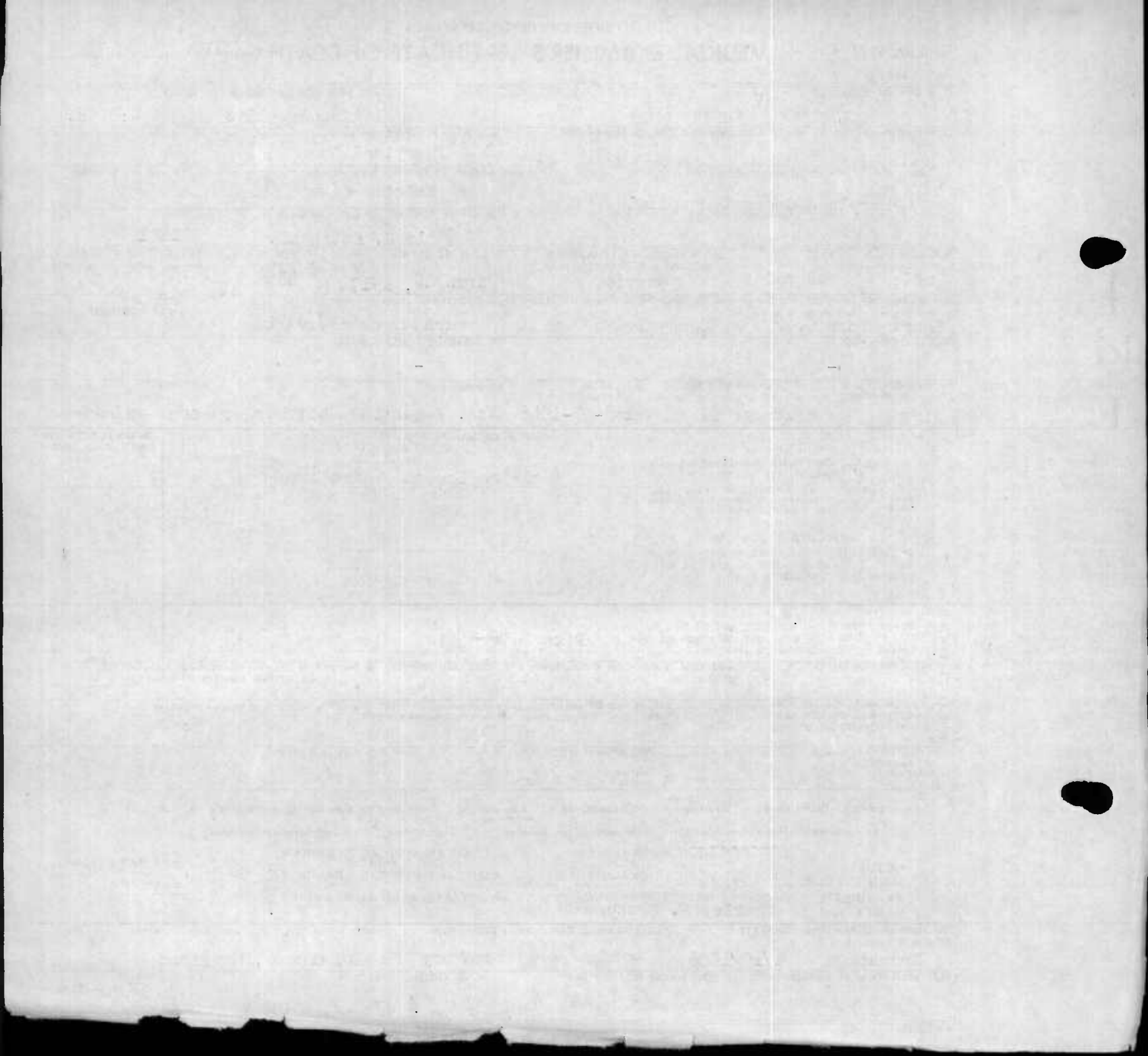
Robert E. Fickel

24C. FUNERAL DIRECTOR

Wm. J. Fickel & Sons

ADDRESS

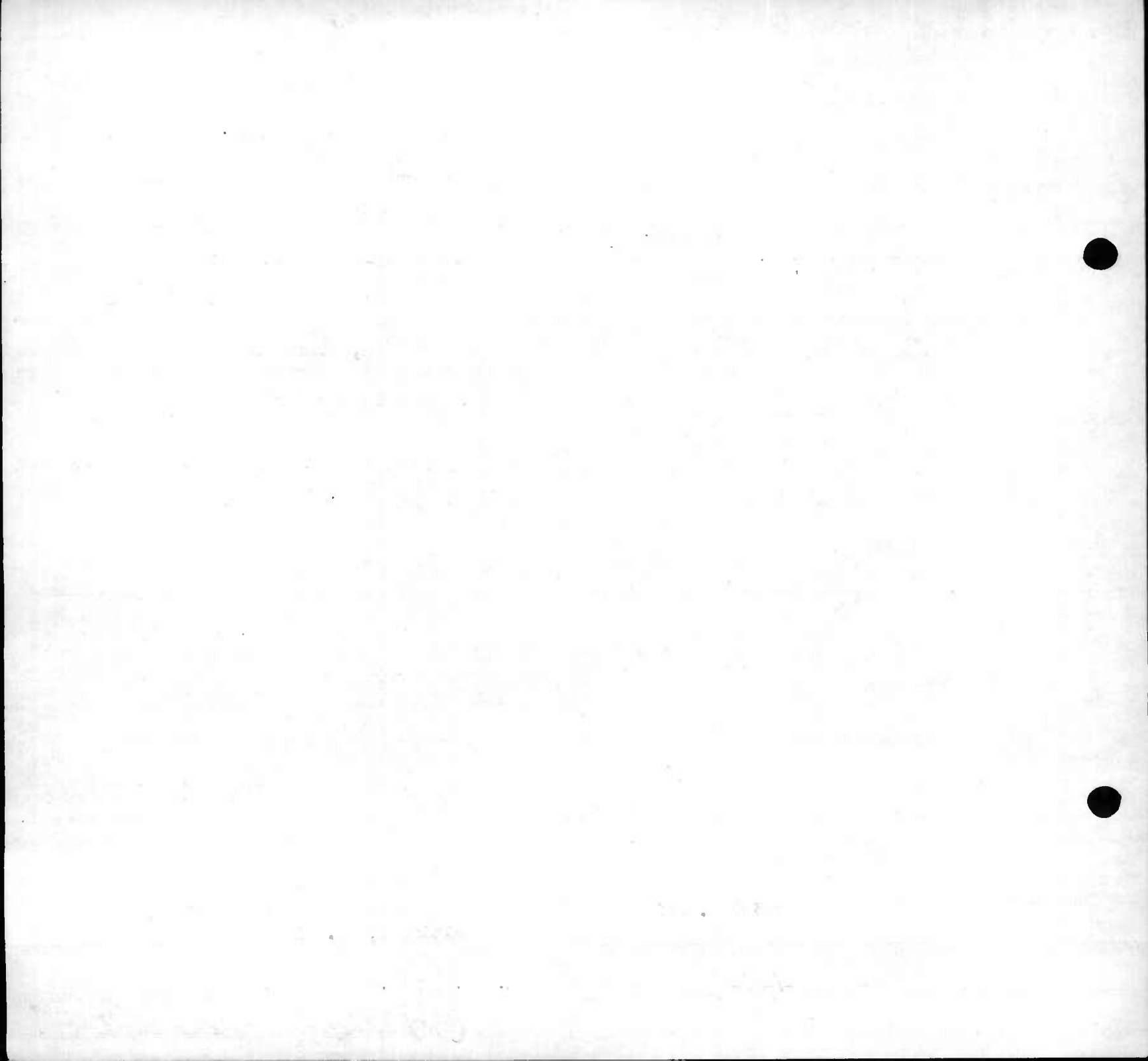
Baltimore, Md.
21201 PA Ave



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

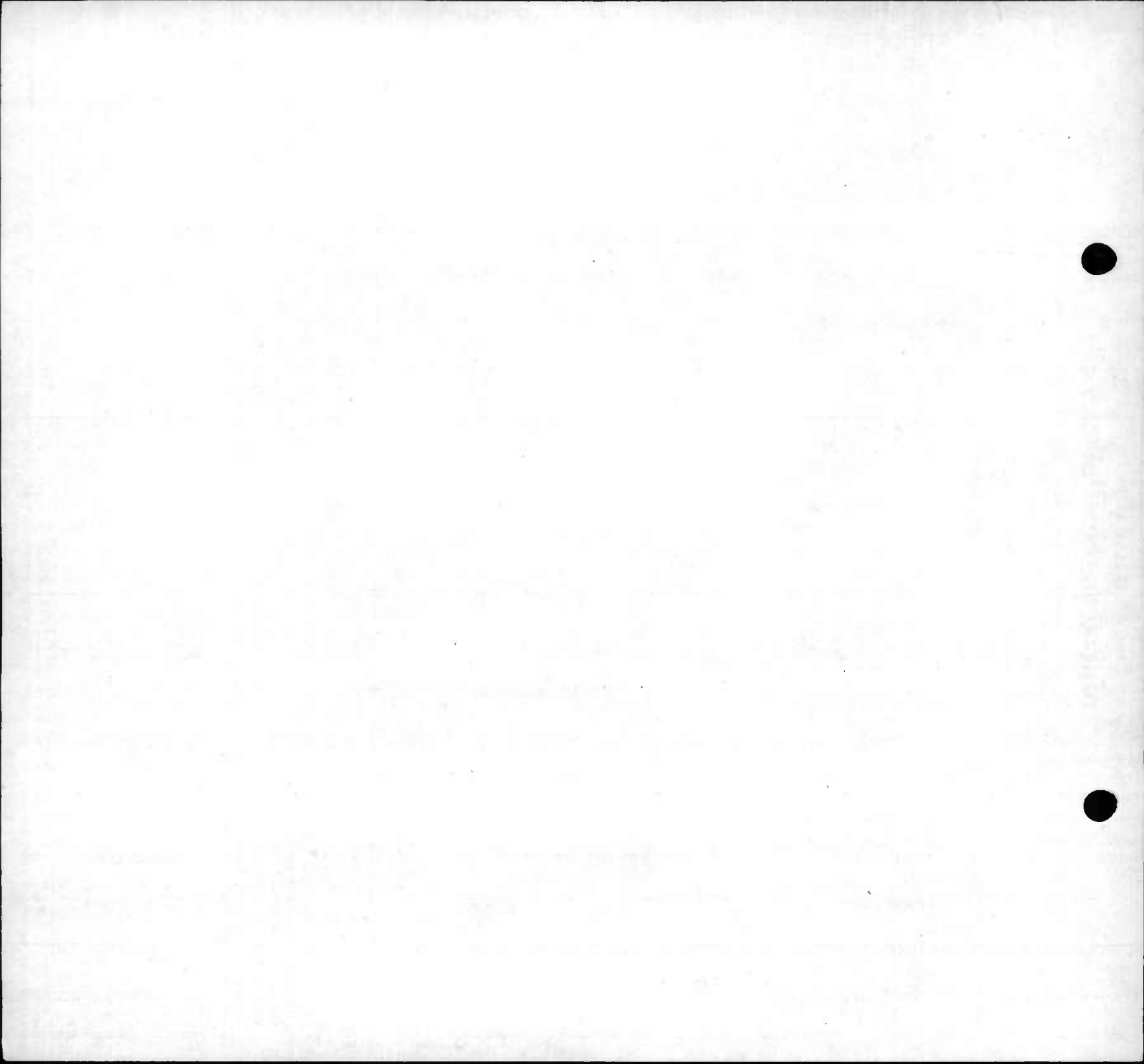
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH									
66 00515		Registered No. 66 00515							
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
				Stitz, Mary Estella			1/15/66 11:55 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Montebello State Hospital				A. STATE		B. COUNTY			
				Maryland		Baltimore			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
				Bundalk 5300					
				D. STREET ADDRESS (If rural, give location)					
				1911 Midland Road					
5. SEX	6. RACE	7. MARRIED NEVER MARRIED WIDOWED DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
Female	White			11/7/1889	76				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife						Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Noah H. Kester				Myers, Elizabeth					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
no				213-36-0089		Hospital Records			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH	
176.1 I Adenocarcinoma of vagina - local extension								3 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				no					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1/15/65 to 1/15/66, that (I) (we) last saw the deceased alive on 1/15/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
Daniel G. Lai				1/15/66					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
Daniel G. Lai				Montebello State Hospital, Baltimore, Md. 21218					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		1/19/1966		Meadowridge Mem. Pk. Cem.		Elkridge, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JAN 17 1966		Robert E. Jones		Robert E. Jones		Baltimore, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00516	
BIRTH NO. 66 00516		CERTIFICATE OF DEATH		Registered No. 66 00516	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CLARENCE ECTOR		2. DATE AND HOUR OF DEATH 13 January 1966 1:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION University Hospital Baltimore, Maryland		D. STREET ADDRESS (If rural, give location) 706 1/2 W. Saratoga St.			
5. SEX M	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 1 Jan 1930	9. AGE (In years last birthday) 36	If Under 1 Yr. Months: Ooys: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Virgil Ector		14. MOTHER'S MAIDEN NAME Alice	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ALICE E. TROUPE 445 CATHERINE ST ELIZABETH, N.J.	
18. 5-70-51 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 20 min	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		(C) DUE TO	
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Surgery for partial intestinal obstruction 10 days	
19A. DATE OF OPERATION 1/13/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED partial intestinal obstruction		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) N/A		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N/A	
21C. WHERE DID INJURY OCCUR? N/A		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) N/A		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> N/A	
21F. HOW DID INJURY OCCUR? N/A		22. I certify that (1) (this hospital) attended the deceased from 31 Dec 1965 to 13 Jan 1966 , that (2) (we) last saw the deceased alive on 13 Jan 1966 and that (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Robert S. Holt		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 13 Jan 66	
23C. PHYSICIAN'S NAME (Type) Robert S. Holt		23D. ADDRESS M.D. University Hospital, Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/17/66		24C. NAME OF CEMETERY or CREMATORY Mt Auburn	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 17 1966		25B. NAME OF REGISTRAR Robert E. Jones	
25C. FUNERAL DIRECTOR Charles Rice		ADDRESS 661 W. Barre St			



FUNERAL DIRECTOR: IMPORTANT

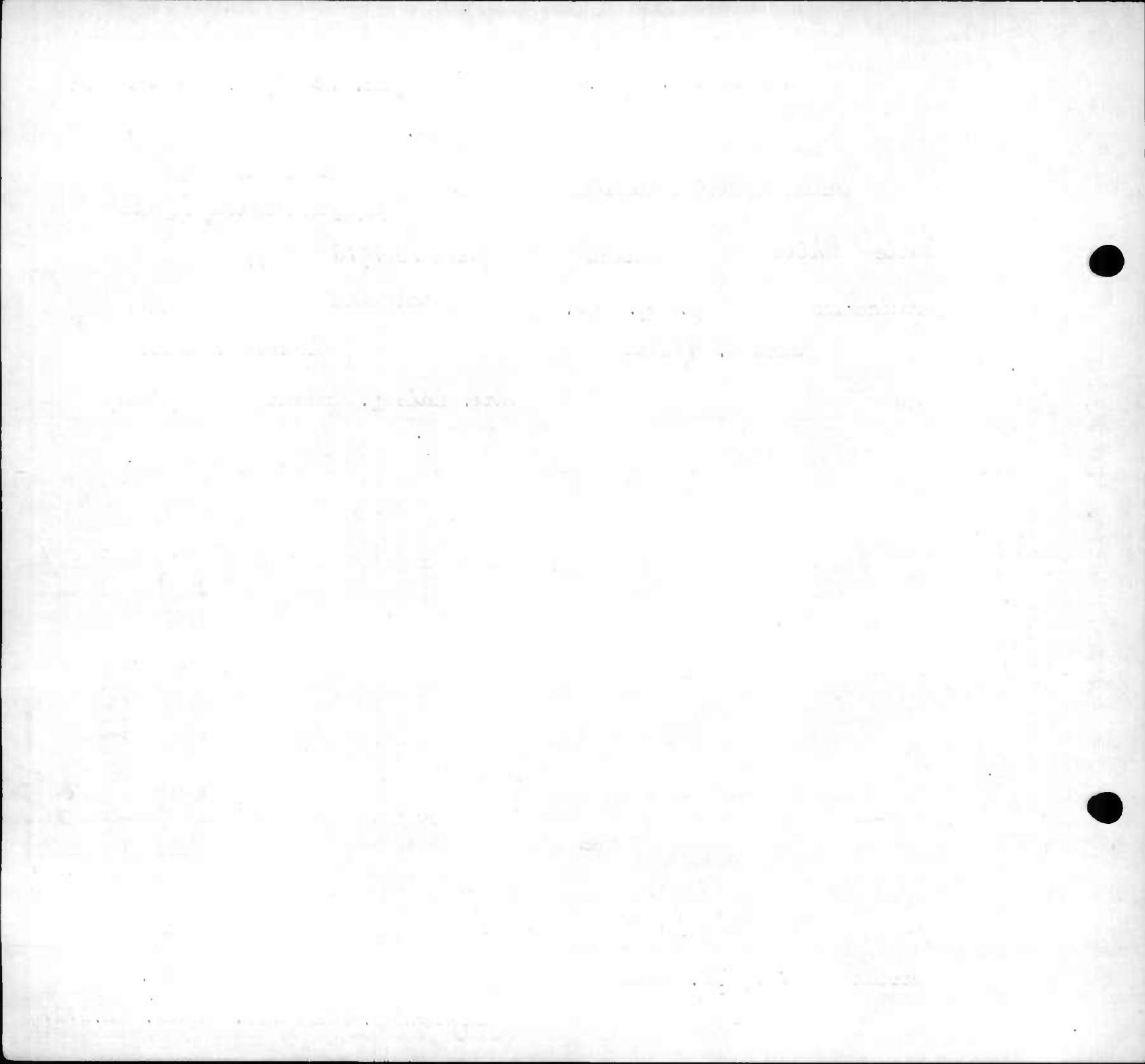
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00517	
BIRTH NO. 66 00517		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Herman Brinker		2. DATE AND HOUR OF DEATH Jan. 15, 1966. 1 12 30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE Md. B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 6305 McClean Blvd.		D. STREET ADDRESS (If rural, give location) 6305 McClean Blvd.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH July 30, 1889	9. AGE (In years last birthday) 76	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Baker		11. BIRTHPLACE (State or foreign country) Holland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 116-26-7345A		17. INFORMANT Mr. Harry Brinker	
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO ASCVD & Congestive Heart Failure (B) DUE TO Diabetes Mellitus (C)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 19 65 to Jan 15 19 66, that (I) (we) last saw the deceased alive on Jan 7 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE George H. Beck		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/17/66	
23C. PHYSICIAN'S NAME (Type) GEORGE H. BECK		23D. ADDRESS 6012 HARTFORD ROAD BALTO MD 21216			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 1/17/66		24C. NAME OF CEMETERY or CREMATORY Greenmount Crematory	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. JAN 17 1966		25B. NAME OF REGISTRAR E. J. Beck		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00518		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00518	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		Kenneth J. Aylmer		2. DATE AND HOUR OF DEATH Jan. 16, 1966. 10:55 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #34	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital		D. STREET ADDRESS (If rural, give location) 2409 Gainsborough Court			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH April 18, 1916	9. AGE (In years last birthday) 49	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Serviceman		10B. KIND OF BUSINESS OR INDUSTRY G. & E. Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James R. Aylmer		14. MOTHER'S MAIDEN NAME Louise Hensler	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Lois E. Aylmer (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ACUTE CORONARY OCCLUSION CORONARY SCLEROSIS PREVIOUS MYOCARDIAL INFARCTION INTERVAL BETWEEN ONSET AND DEATH 11 years 1954		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		20B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from December 14, 1954 to December 31, 1965, that (I) (we) last saw the deceased alive on December 31, 1965, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Melvin F. Polek		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Jan. 17, 1966	
23C. PHYSICIAN'S NAME (Type) MELVIN F. POLEK		23D. ADDRESS M.D. 3603 BELAIR ROAD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/19/66		24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 17 1966		25B. NAME OF REGISTRAR Leonard J. Ruck Inc.	
25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.		ADDRESS Balto. Md. 21214			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		66 00519		66 00519	
BIRTH NO.		M.E. CASE NO.		REGISTERED No.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Lettie E. Collenberg		Jan. 15, 1966		3 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland			
5503 Gwynn Oak Ave.		B. COUNTY Baltimore			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 5503 Gwynn Oak Avenue			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH Feb. 12, 1886	9. AGE (In years last birthday) 79	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Smith		14. MOTHER'S MAIDEN NAME ? Wilson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-16-6485		17. INFORMANT Mrs. Dorothy Miciche	
				ADDRESS Belair Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cerebral Accident		INTERVAL BETWEEN ONSET AND DEATH Several years			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO Hypertension		(B) DUE TO Arterio Sclerosis	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1963 to Jan 15 1966, that (I) (we) last saw the deceased alive on Dec 14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lee J. Volenick		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/15/66	
23C. PHYSICIAN'S NAME (Type) Lee J. Volenick		23D. ADDRESS 4710 Liberty Ave Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/18/66		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 17 1966		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Leonard J. Rubk Inc 5305 Harford Rd.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>66 00520</u>	
BIRTH NO. <u>66 00520</u>							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <u>Korrell, Amelia Dolley (Esler)</u>		2. DATE AND HOUR OF DEATH <u>1-16-1966 4:45p. M.</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>27-02</u>					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Union Memorial Hospital</u> <u>Baltimore, Maryland</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>					
D. STREET ADDRESS (If rural, give location) <u>2302 E. Cold Spring Lane</u> <u>Baltimore, Maryland 21214</u>							
5. SEX <u>Female</u>	6. RACE <u>Caucasian</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>4/13/1888</u>	9. AGE (If years lost birthday) <u>77</u> <u>84</u>	10. Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Frank Dolley</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No Unknown</u>		16. SOCIAL SECURITY NO. <u>216-10-8365D</u>		17. INFORMANT <u>Mr. Leroy Esler</u>		ADDRESS <u>(Same)</u>	
18. <u>4-51X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Ruptured thoracic aortic aneurysm</u>		CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO				(B) DUE TO	
		(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Except thoracic aortic aneurysm 1-15-66</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>No</u>		21C. WHERE DID INJURY OCCUR? <u>No</u>		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>Not</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Not</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 15</u> 19 <u>66</u> to <u>Jan 16</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Jan 16</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Yang Fan</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>1-16-1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR. KANG FAN</u>				23D. ADDRESS <u>Union Memorial Hospital</u> <u>Baltimore Maryland 21218</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/19/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 17 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md. 21214</u>		ADDRESS	

See letter in file - Bureau of Biological Services
American Embassy

AT 3 1 1

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 00521

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Joseph Tipman

2. DATE AND HOUR PRONOUNCED DEAD

1/14/66

2:30 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

8. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

603 Wildwood Pkwy.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

June 7/83

9. AGE (In years
last birthday)

82

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF
WHAT COUNTRY

USA

13. FATHER'S NAME

Ernest Tieperman

14. MOTHER'S MAIDEN NAME

Marie

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Mrs. Joe Tipman

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

1/14/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JAN 17 1966

P. J. F. J. J.

Witke 710.4101 Edmondson

WALLACE COLLEGE

WASHINGTON

NOV 1

James H. King

45-59-19 |
NW

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 66 00522 ✓

BIRTH NO. 66-60030 66 00522		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) <u>BABY GIRL (Catherine) BELSER</u>		2. DATE AND HOUR OF DEATH <u>JANUARY 3, 1966</u> <u>2⁰⁰</u> <u>A</u> M.	
3. PLACE OF DEATH <u>IN BALTIMORE, MARYLAND</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>13-01</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>BALTIMORE CITY HOSPITAL</u> <u>4940 Eastern Avenue, Baltimore, Md. 21224</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>	
D. STREET ADDRESS (If rural, give location) <u>2416 Callow Avenue 21217</u>			
5. SEX <u>F</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED , WIDOWED, DIVORCED (Specify) <u>Never Married</u>	8. DATE OF BIRTH <u>JAN 2, 1966</u>
9. AGE (In years last birthday)		10. AGE (In years last birthday)	11. AGE (In years last birthday)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>N.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Belser.</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE McDonald.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT RECORDS: <u>BCH, 4940 Eastern Avenue Balto. Md. 21224</u> <u>Mother-</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>762.51</u> <u>PRIMARY ATELECTASIS</u> <u>8hr-</u>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(A) DUE TO <u>Prematurity</u> (B) DUE TO (C) DUE TO	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>JAN 2</u> 19 <u>66</u> to <u>Jan 3</u> 19 <u>66</u> , that (1) (we) last saw the deceased alive on <u>Jan 3</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>J.E. Randall</u>		23B. DATE SIGNED <u>Jan 3, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>J.E. RANDALL</u>		23D. ADDRESS <u>4940 Eastern Avenue, Balto. Md. 21224</u> <u>Balto City Hosp-</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>1-6-66</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Baltimore City Hospitals Baltimore, Maryland 21201</u>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 17 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Galt</u>	
25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u>		25D. ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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1000 1000
1000 1000

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00523	
BIRTH NO. 66-00016 66 00523				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) BABY BOY SMITHSON, Mary Lee				1-4-'66 8 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITAL 4940 Eastern Avenue, Balto. Md., 21224				A. STATE MARYLAND	
				B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
				D. STREET ADDRESS (If rural, give location)	
				2416 E. Biddle Street - 21213	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Infant	8. DATE OF BIRTH 1-3-'66	9. AGE (In years last birthday) 36	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
			MARYLAND		LI. S. A.
13. FATHER'S NAME UNKNOWN			14. MOTHER'S MAIDEN NAME MARY LEE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
					RECORDS: BCH, 4940 Eastern Ave., Balto. Md. 21224
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) PREMATURITY			INTERVAL BETWEEN ONSET AND DEATH 3 1/2 h.		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/3 19 66 to 1/4 19 66, that (I) (we) last saw the deceased alive on 1-4-'66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE M. Peterson				23B. DATE SIGNED 1-4-'66	
23C. PHYSICIAN'S NAME (Type) M. PETERSSON				23D. ADDRESS 4940 Eastern Ave., Balto., Md. 21224 6144 E. PRATT ST. BALTO	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Cremation		1-7-66		Baltimore City Hospital, Baltimore, Maryland 21224	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 17 1966		P. J. S. J. S. J.		HOSPITAL DISPOSAL	

BRITISH MOUNTAIN CORPS

1-3-66

MARYLAND

MARY LEE

UNKNOWN

THE MOUNTAIN

222

M. Robinson

M. BETH 5220 M

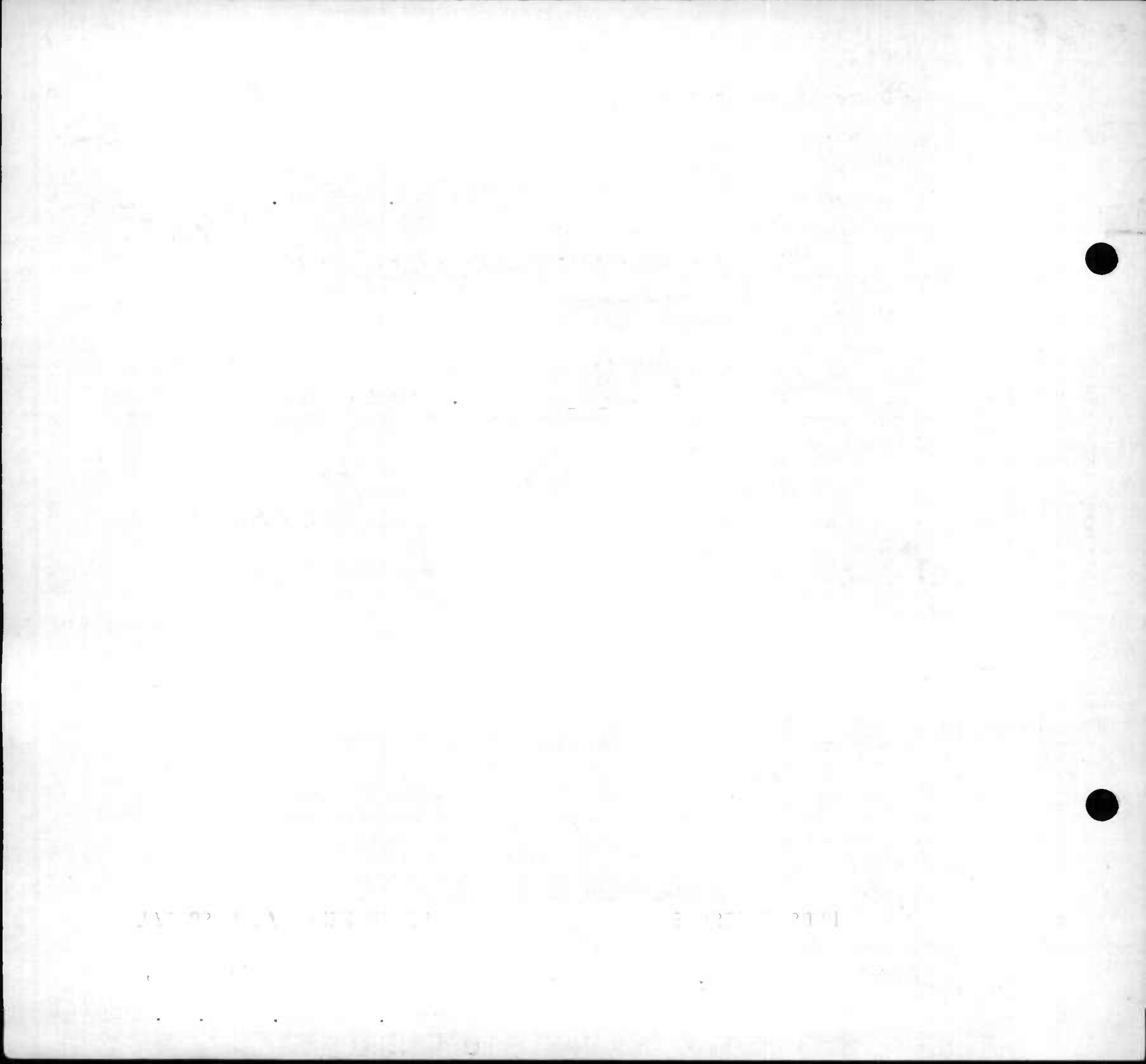
614 E. PRAT. ST.

X

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00524	
BIRTH NO. 66 00524		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>DR Louis D. Knightly</i>		2. DATE AND HOUR OF DEATH <i>1/14/66 8:30 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>8-05</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hosp</i>		D. STREET ADDRESS (If rural, give location) <i>1513 E. North Ave. 2329 N. Charles St</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>12/17/85</i>	9. AGE (In years last birthday) <i>80</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Chiropractor</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Patrick Knightly</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Breen</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-38-9692</i>		17. INFORMANT <i>Mrs. Catherine Knightly</i>	
ADDRESS <i>(Same)</i>		18. CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO <i>pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 wk</i>	
		(B) DUE TO <i>CVA</i>		<i>1 yr</i>	
		(C) <i>Jul</i>			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1/13</i> 19 <i>66</i> to <i>1/14</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>1/14</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Hudson Fesche</i> M.D.				23B. DATE SIGNED <i>1/14/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>HUDSON FESCHE</i> M.D.				23D. ADDRESS <i>UNION MEMORIAL HOSPITAL</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/17/66</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md,</i>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc. Balto. Md. 21214</i>			
25D. ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00525	
BIRTH NO. 66 00525		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Susan V. Baquell</i>			2. DATE AND HOUR OF DEATH <i>1-14-66 11:45 A.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Mercy Hospital</i>			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>6-01</i>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #24</i>		
			D. STREET ADDRESS (If rural, give location) <i>21 N. Potomac St.</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>12-26-82</i>	9. AGE (In years last birthday) <i>83</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>John Smith</i>			14. MOTHER'S MAIDEN NAME <i>Kunigunda</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mrs. Mary Zacharski</i>		ADDRESS <i>(Same)</i>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>420.11x260X</i> CAUSE OF DEATH (A) DUE TO <i>CVA (Cerebral hemorrhage, brain infarct)</i> (B) DUE TO (C) <i>HASCVD</i>			INTERVAL BETWEEN ONSET AND DEATH <i>hours.</i> <i>years.</i>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Diabetes Mellitus</i>			20. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>years</i>		
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <i>1-14-66 11:00am</i> to <i>1-14-66 11:40am</i> , that (I) (we) last saw the deceased alive on <i>1-14-66 11:40am</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Carmelita A. Cerdano, M.D.</i>			23B. DATE SIGNED <i>1-14-66</i>		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>1/18/66</i>	24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc. Balto. Md. 21214</i>	
ADDRESS <i>21214</i>					

AVA (Central branch)
(Branch office)

442240

Private Justice

George A. Gordon, Jr.

x

1-14-46

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

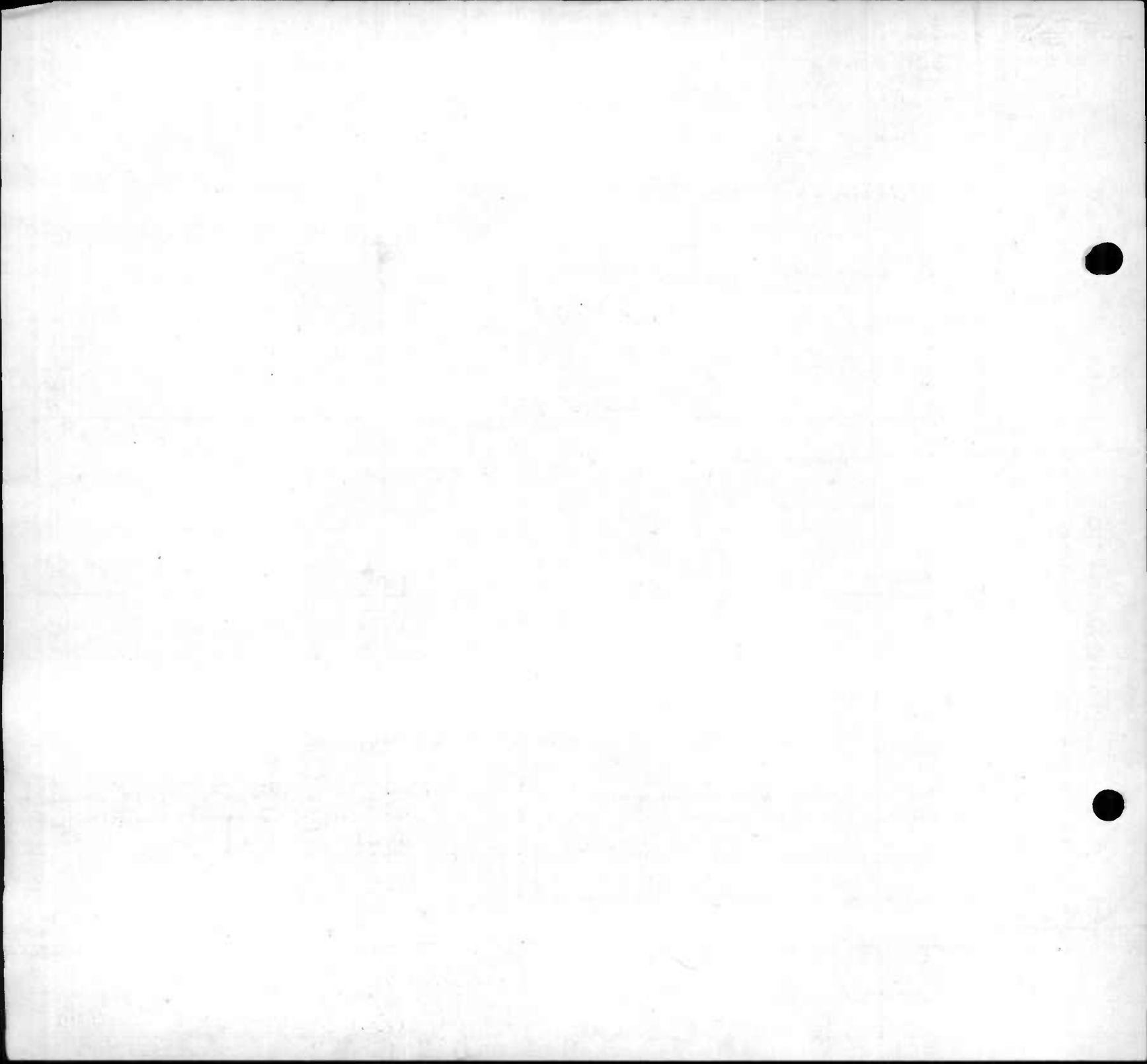
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00526	
BIRTH NO. 66 00526		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Logiudice, Joseph		January 14, 1966 1:15 p. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
			Maryland, Baltimore 6-03		
33 Johns Hopkins Hospital			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			Baltimore		
			D. STREET ADDRESS (If rural, give location)		
			2306 E. Baltimore Street		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
Male	White	Married	10-16-92	70 73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Real estate sales		Real estate	Messina, Italy		U.S.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Carmen Logiudice			Mary Puglia		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS
No		219-12-5494	Mrs. Sarah LoGiudice		(Same)
18. 443 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) Intracranial hemorrhage		
			(B) Hypertensive cardiovascular disease		
			(C)		
INTERVAL BETWEEN ONSET AND DEATH			48 hours		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			None known		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			No		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?		
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from January 12, 1966 to January 14, 1966, that (I) (we) last saw the deceased alive on January 2 14, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Edgar W. Hull M.D.				1-14-66	
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Edgar W. Hull			Johns Hopkins Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	1/18/66	Holy Redeemer Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
				Leonard J. Ruck Inc. Balto. Md. 21214	

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FUNERAL DIRECTOR: IMPORTANT

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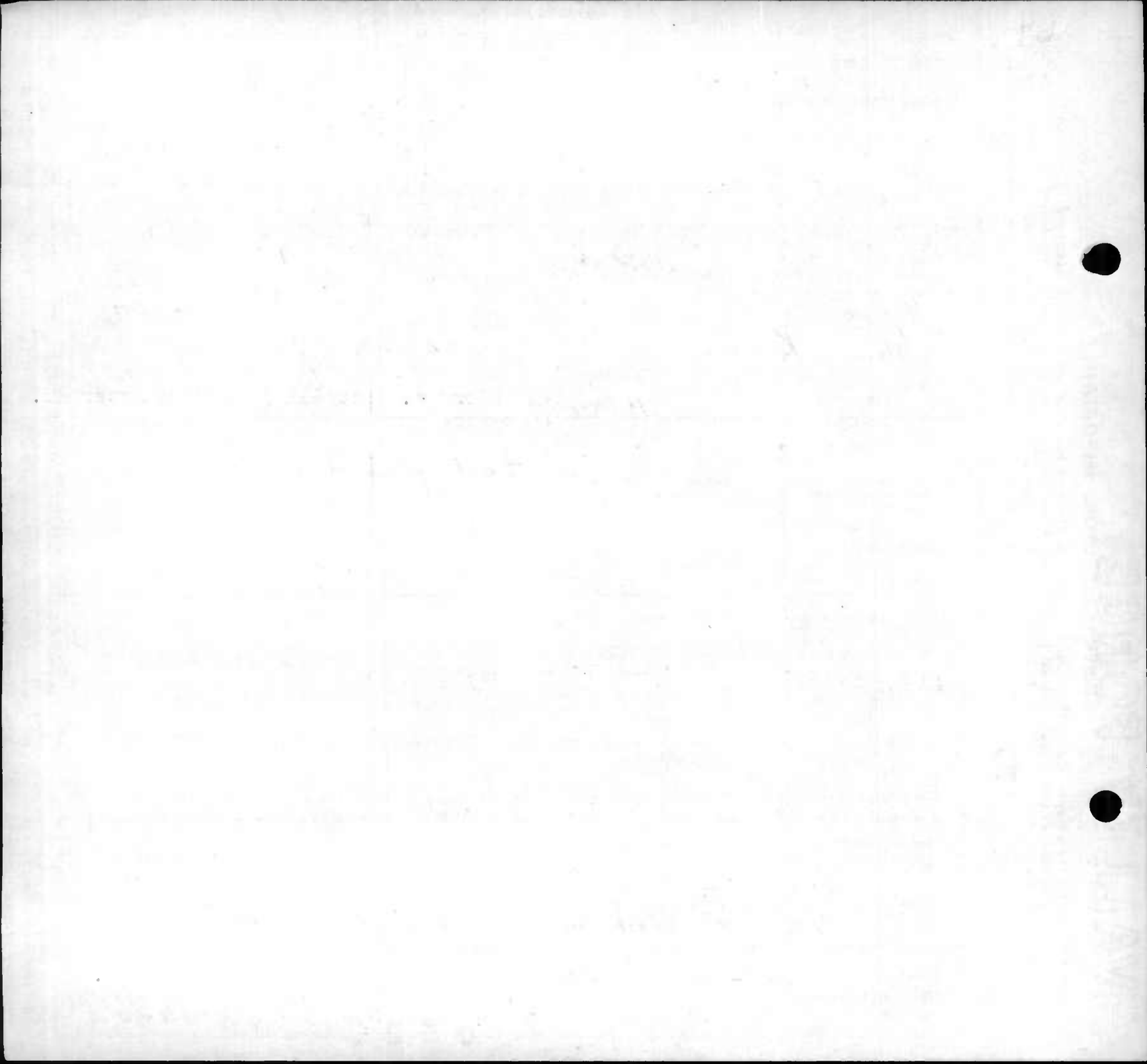
BIRTH NO. 66 00527		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00527	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HENSON, SAMUEL			2. DATE AND HOUR OF DEATH 1-14-66 4:45 P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE MARYLAND		
46 LUTHERAN HOSPITAL OF MARYLAND			B. COUNTY Baltimore		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			BALTIMORE		
			D. STREET ADDRESS (If rural, give location)		
			105 NEWCUT RD.		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days
MALE	COLORED	WIDOWED	1-8-88	77	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
EMPLOYEE TEL. CO.		SELF EMPLOYED		ELICOTT CITY	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
NICK HENSON			UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		212-050670		JOHN - SON 2332 MOSHER ST	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)			(A) DUE TO Cerebral Hemorrhage?		
ANTECEDENT CAUSES			(B) DUE TO Subarachnoid		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) DUE TO Ischemic myelitis		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nailify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1-9-66 to 1-14-66, that (I) (we) last saw the deceased alive on 1-14-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Dahlin Krieger				1-14-66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
MORTON KRIEGER					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		1/18/66		WESTERN STAR CEMETERY CATONSVILLE MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 17 1966		J. J. J. J.		Wilton Webb, 3613, Dennis Rd	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

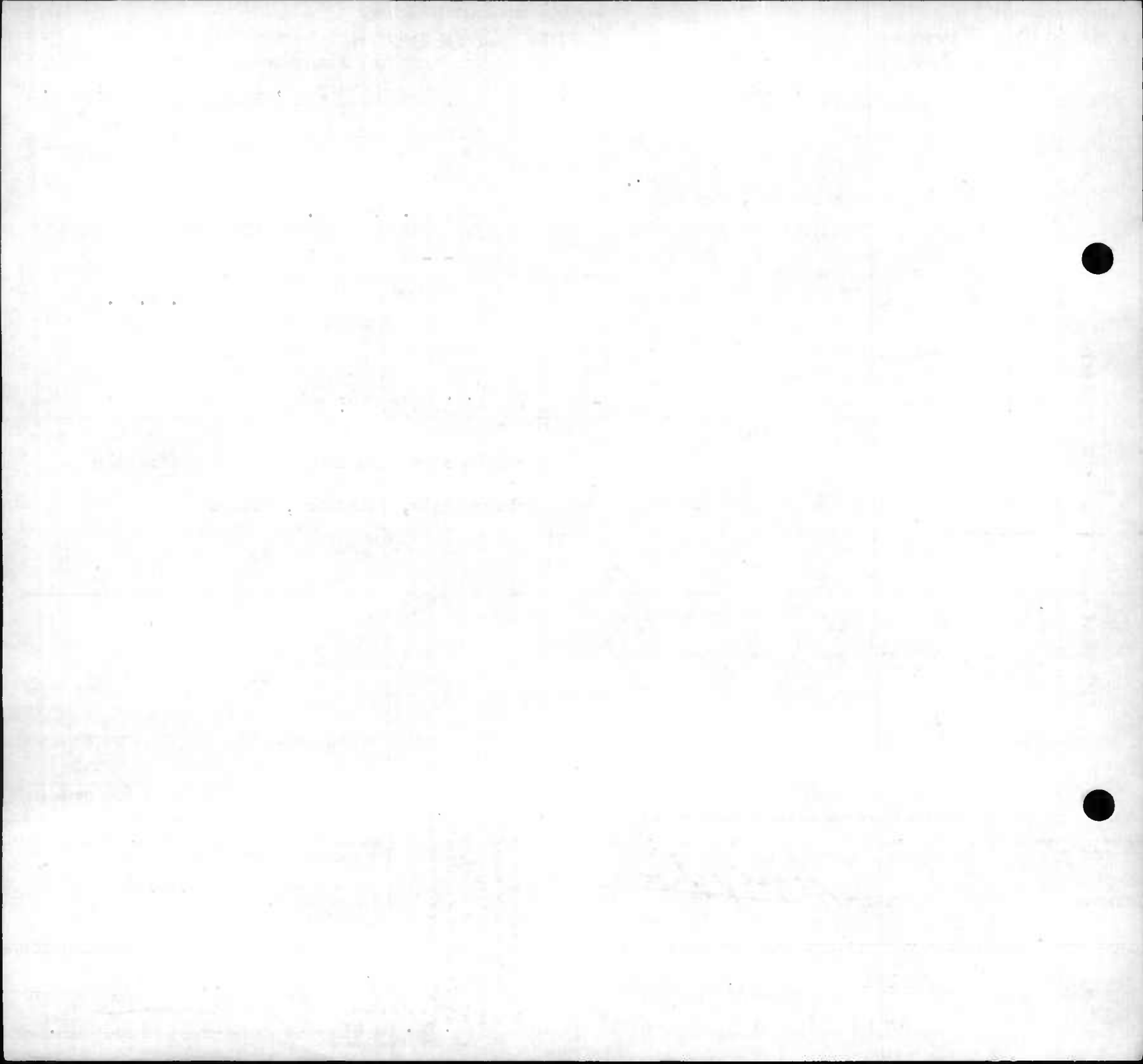
BALTIMORE CITY HEALTH DEPARTMENT									
66 00528 CERTIFICATE OF DEATH					Registered No. 66 00528				
1. NAME OF DECEASED (Type or Print) FLORA B. LUTTRELL					2. DATE AND HOUR OF DEATH 1-14-66 6¹⁰ AM.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hosp.					A. STATE Maryland B. COUNTY 15-11				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
					D. STREET ADDRESS (If rural, give location) 3205 Dorchester Rd.				
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 1-13-1887	9. AGE (In years last birthday) 79	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore - Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Keller			14. MOTHER'S MAIDEN NAME Martha January						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 213-20-2079		17. INFORMANT ADDRESS Flora J. Luttrell 3205 Dorchester Rd.				
18. 578X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Heart failure - post gastrectomy					INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 12-30-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED upper GI Bleeding		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 11-21-1965 to 1-14-1966 , that (I) (we) last saw the deceased alive on 1-14-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Nabil F. Warsal M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-14-66		
23C. PHYSICIAN'S NAME (Type) Nabil F. WARSAL M.D.					23D. ADDRESS Maryland Gen. Hosp.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-17-1966		24C. NAME OF CEMETERY or CREMATORY Woodlawn		24D. LOCATION (City, town, or county) (State) Woodlawn Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 17 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR E. Howard Strong		ADDRESS 3707 W. North Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

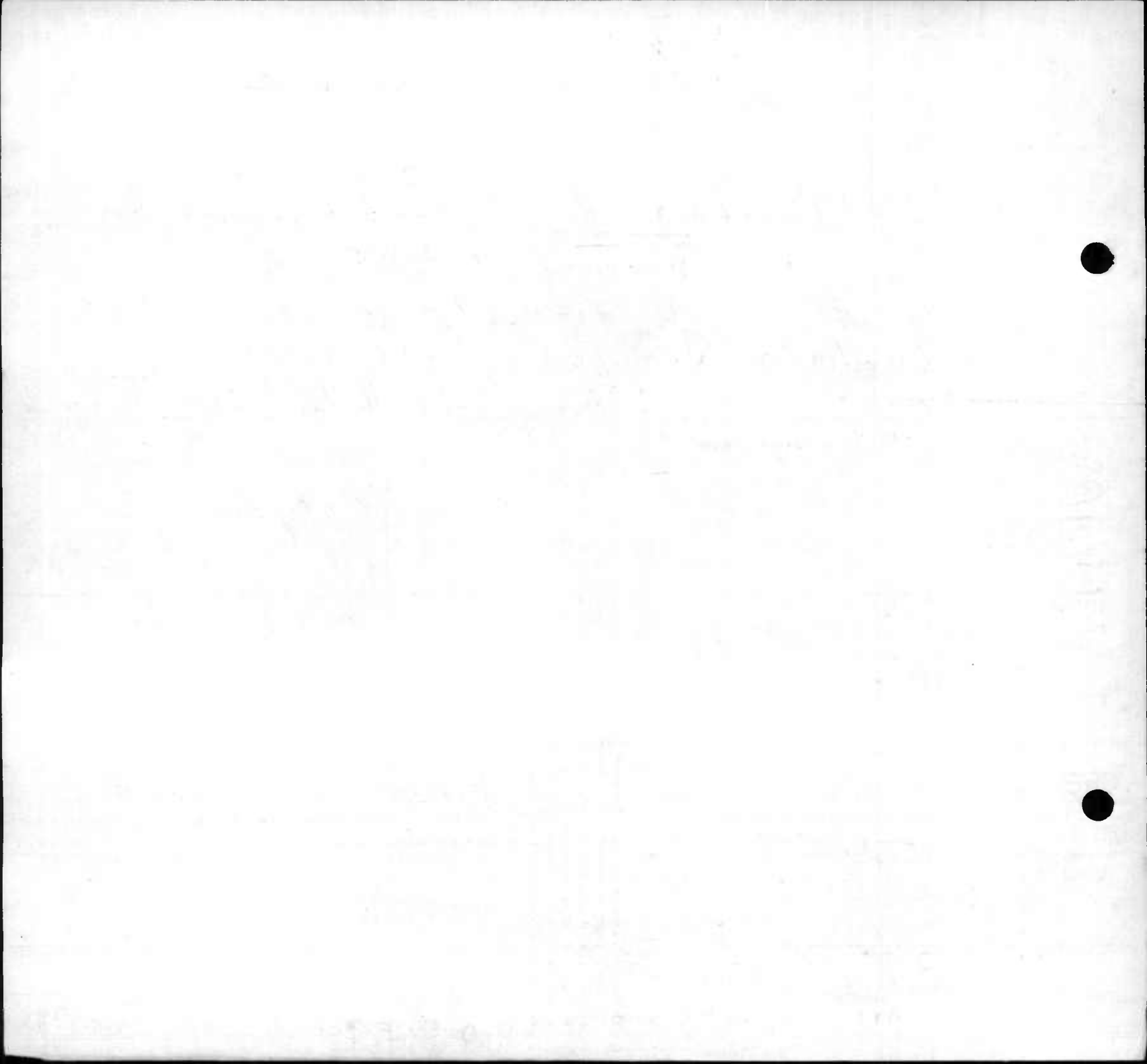
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 00529</u>	
BIRTH NO. <u>66 00529</u>		CERTIFICATE OF DEATH			
M.E. CASE NO. <u>66 00529</u>					
1. NAME OF DECEASED (Type or Print) <u>PEARL, Oscar Lee</u>		2. DATE AND HOUR OF DEATH <u>January 14, 1966</u> <u>4:00 A. M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Veterans Administration Hospital</u> <u>3900 Loch Raven Blvd.</u> <u>Baltimore, Maryland 21218</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>814 St. Paul St.</u>			
5. SEX <u>Male</u>	6. RACE <u>Caucasian</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never Married</u>	8. DATE OF BIRTH <u>11-8-92</u>	9. AGE (In years last birthday) <u>73</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
13. FATHER'S NAME <u>Daniel Pearl</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>6/28/18 to 1/28/19</u>		16. SOCIAL SECURITY NO. <u>213-12-7327</u>		17. INFORMANT <u>Records</u> ADDRESS <u>V.A. Hospital, 3900 Loch Raven Blvd.</u> <u>Baltimore, Md. 21218</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>162.14.1 002.1</u> <u>Bronchogenic Carcinoma</u>		CAUSE OF DEATH (A) DUE TO <u>Tuberculosis, Pulmonary, Active</u> (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <u>December 15</u> <u>1965</u> to <u>January 14</u> <u>1966</u> , that (X) (we) last saw the deceased alive on <u>January 14</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED <u>1/14/66</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/17/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National</u>	
24D. LOCATION <u>Baltimore Co., Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 17 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>W. E. Johnson</u> ADDRESS <u>8521 Loch Raven Bl.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

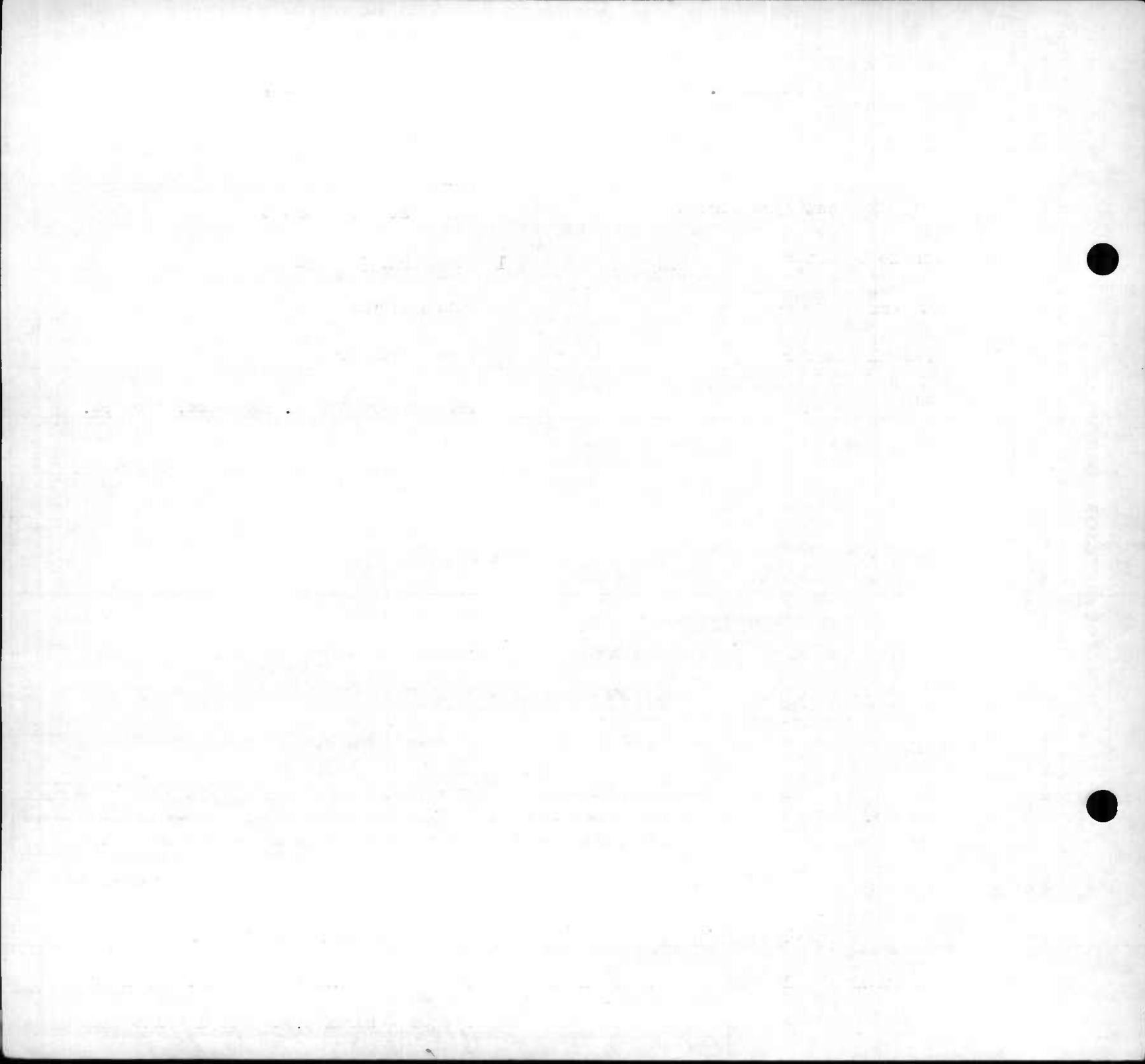
BIRTH NO. 66 00530		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00530	
M.E. CASE NO.		MAY-A. CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Walter Rader</i>		2. DATE AND HOUR OF DEATH 1-13-66 <i>1 P</i> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>27-02</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>3002 Overland Ave</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If inst., give location) <i>3002 Overland Ave</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>1-2-1886</i>	9. AGE (In years last birthday) <i>80</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Ferdinand Jungfer</i>		14. MOTHER'S MAIDEN NAME <i>Wilhelmina</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Walter H. Rader</i> ADDRESS <i>2522 Hanson Rd</i>	
18. <i>420.1</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <i>Ar dead arrest</i> (B) DUE TO <i>Coronary Artery Disease</i> (C)		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>Yrs.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Arteriosclerotic Heart Disease</i>		<i>Yes.</i>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6/8/65</i> 19 to <i>1/13/66</i> 19, that (I) (we) last saw the deceased alive on <i>10/8/65</i> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Walter Rader</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>1/14/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>WALTER E. KARFGIN</i>		23D. ADDRESS <i>4331 HARFORD Rd Balto. Md</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>1/17/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>ST. John's Lutheran</i>	
24D. LOCATION <i>BALTO</i>		24E. LOCATION (City, town, or county) (State) <i>MD</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 18 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>G. F. Evans & Son</i> ADDRESS <i>8802 HARFORD Rd</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

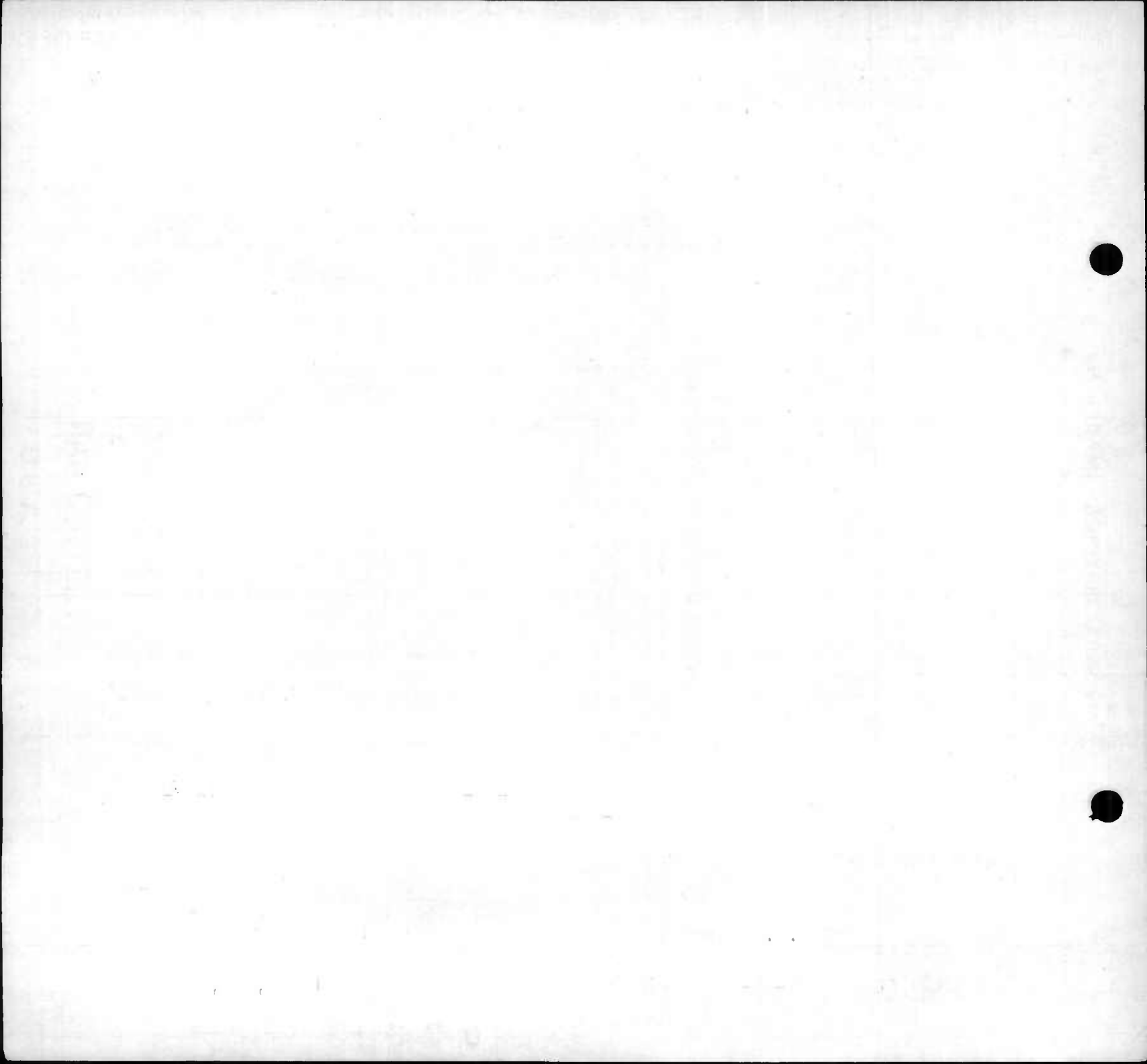
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>66 00531</u>	
BIRTH NO. <u>66 00531</u>							
M.E. CASE NO. <u>66 00531</u>							
1. NAME OF DECEASED (Type or Print) <u>Estelle E. Roe</u>				2. DATE AND HOUR OF DEATH <u>January 12, 1966</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>622 West 33rd Street</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>13-06</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>622 West 33rd Street</u>			
5. SEX <u>Female</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1 November 1873</u>	9. AGE (In years last birthday) <u>92</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Emanuel Sheffer</u>				14. MOTHER'S MAIDEN NAME <u>Leah Kerchner</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Emma Witmer 726 W. Princess, York Pa.</u>			
18. <u>331X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) <u>Cerebro-vascular accident</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>	
(B) <u>Hypertension</u> DUE TO				(C) <u>Hypertension</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Oct. 26</u> 19 <u>64</u> to <u>Jan. 12</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Jan. 6</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Reuben Hoffman</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>1-14-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Reuben Hoffman</u>				23D. ADDRESS M.D. <u>846 West 36th Street</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>15 Jan 66</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore County, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 18 1966</u>		25B. NAME OF REGISTRAR <u>R. E. Hoffman</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Bargee Funeral Home 3631 Falls Road</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

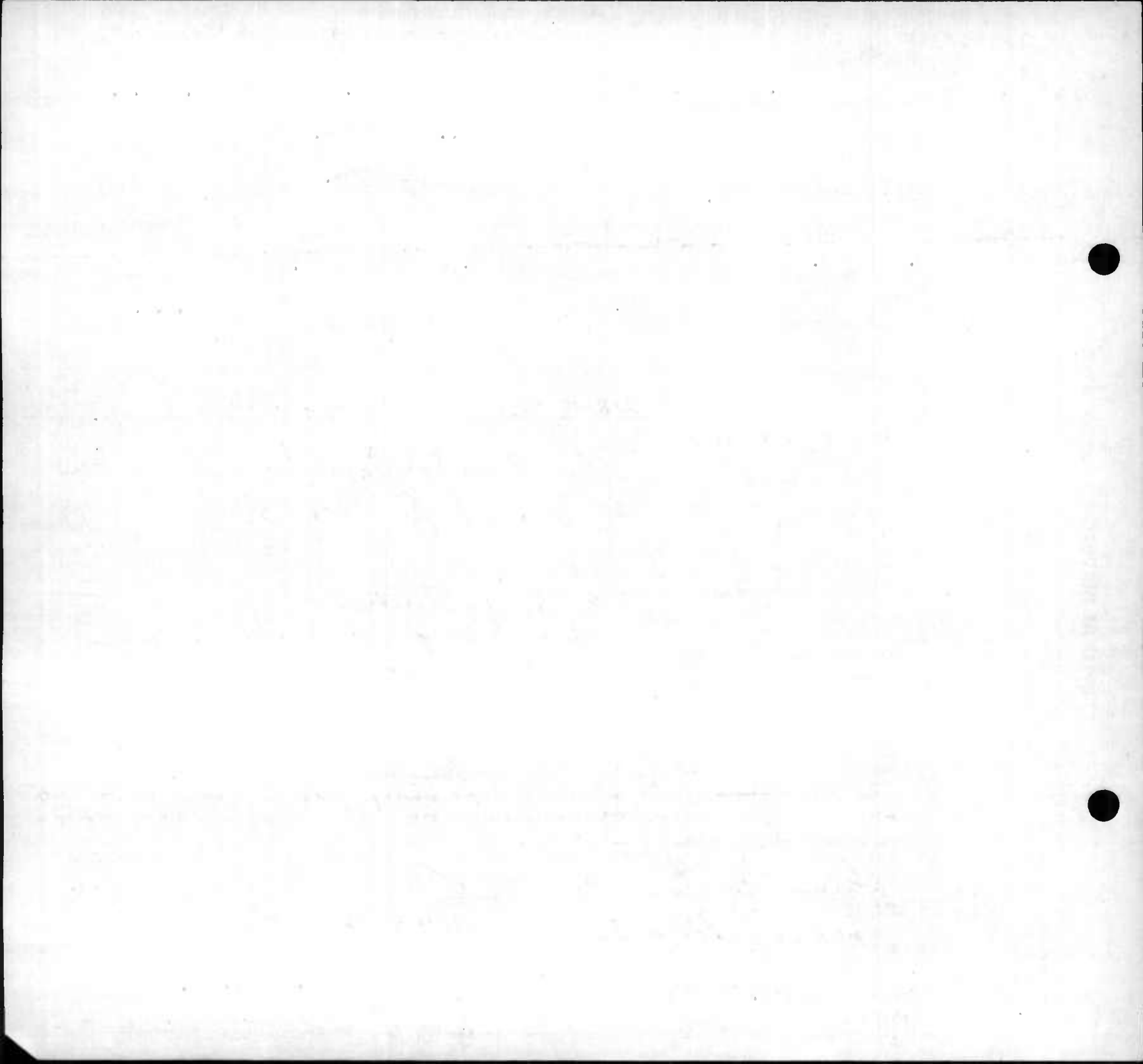
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 00532</u>	
BIRTH NO. <u>66-01853</u> <u>66 00532</u>				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>ORANGE, BABY BOY</u>			
2. DATE AND HOUR OF DEATH <u>1-15-66</u> <u>11 59</u> <u>PM</u>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>15-11</u>		5. SEX <u>Male</u> 6. RACE <u>Negro</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Never</u>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		8. DATE OF BIRTH <u>1-15-66</u> 9. AGE (In years last birthday) <u>Never</u>			
D. STREET ADDRESS (If rural, give location) <u>3502 Llanowr Rd.</u>		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Leewood Johnson</u>			
14. MOTHER'S MAIDEN NAME <u>Renee Orange</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give work dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. <u>776 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <u>IMMATURITY</u> (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES.</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1-15-66</u> 19 to <u>1-15-66</u> 19, that (I) (we) last saw the deceased alive on <u>1-15-66</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>W.C. Johnson</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>1-15-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOHN W.C. JOHNSON</u> M.D.				23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u>		24B. DATE <u>1-15-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>JOHNS HOPKINS HOSPITAL</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, 5, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 18 1966</u>			
25B. NAME OF REGISTRAR <u>Robert S. Johnson</u>		25C. FUNERAL DIRECTOR ADDRESS <u>HOSPITAL DISPOSAL</u>			



FUNERAL DIRECTOR: IMPORTANT


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

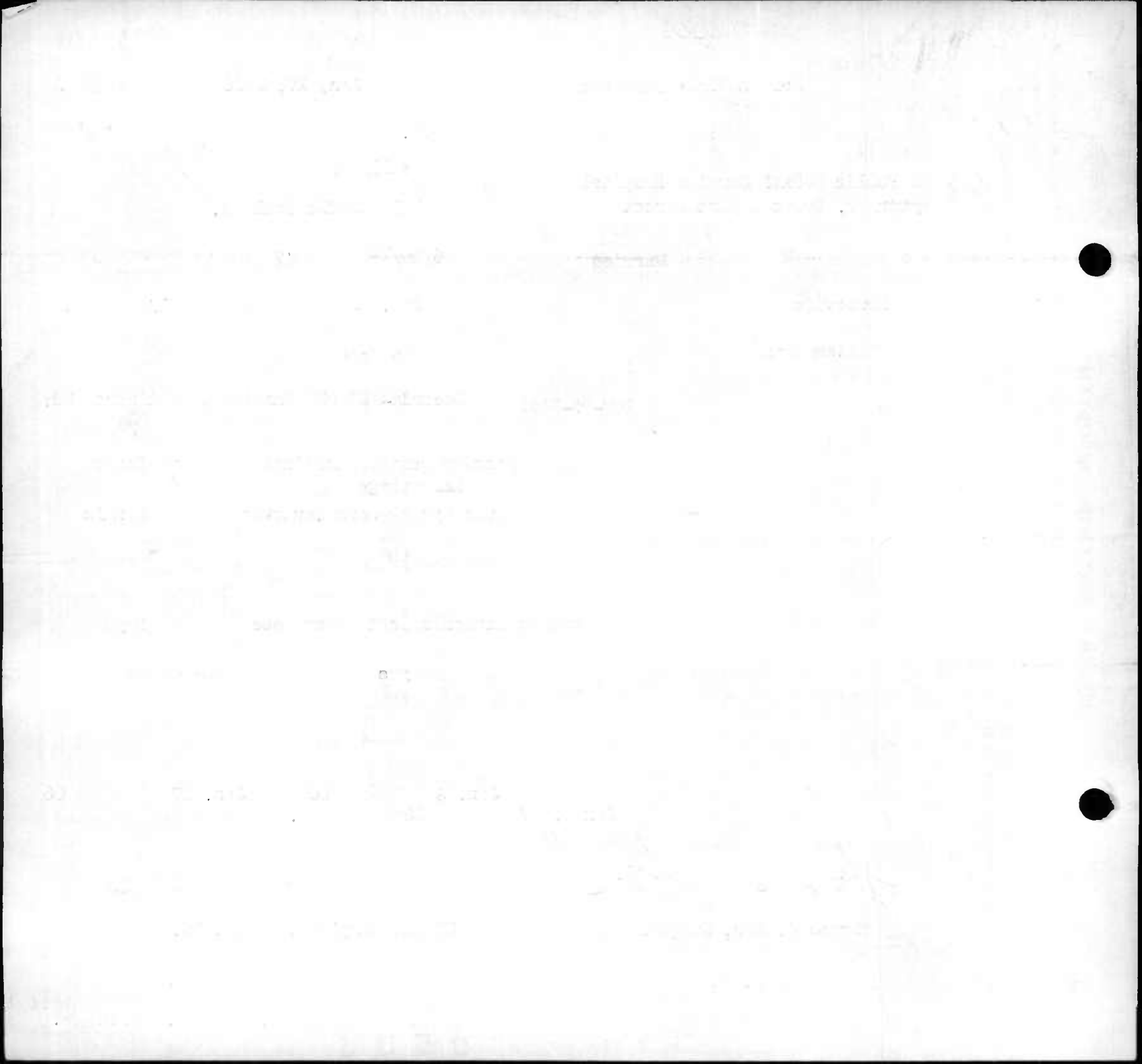
BALTIMORE CITY HEALTH DEPARTMENT									
66 00533					66 00533				
BIRTH NO.					REGISTERED NO.				
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
DR. DAVID M. RANKIN					JAN. 16 th 1966 10.00 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY				
4119 FOREST PARK AVE.					MD. BALTO.				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					BALTIMORE.				
					D. STREET ADDRESS (If rural, give location)				
					4119 Forest Park Ave.				
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)	
M.		W.		MARRIED		DEC. 12 1891		74.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
DOCTOR				OPTOMETRIST		RUSSIA		U.S.A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
MENDEL RANKIN					LEIBA ZUSEV				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
NO					218-10-9886		MRS DAVID RANKIN 4119 FOREST PARK AVE		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) DUE TO				
ANTECEDENT CAUSES					Myocardial Infarction				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO				
					Generalized ASCVD				
					(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					Interval BETWEEN ONSET AND DEATH				
Cancer of prostate					minutes				
Chronic Lymphocytic Leukemia					One Year				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
0				NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from January 1964 to January 16 1965, that (H) (we) last saw the deceased alive on January 16 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED	
HERMAN BRECHER								1/17/66	
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
HERMAN BRECHER					M.D. 443 E. 25th ST.				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
BURIAL		JAN. 17 1966		HEBREW YOUNG MEN		WINDSOR MILL RD. BALTO. Md.			
25A. DATE REC'D BY HEALTH DEPT		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JAN 18 1966		J. Lewis		J. Lewis		100 EUTAW PLACE			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

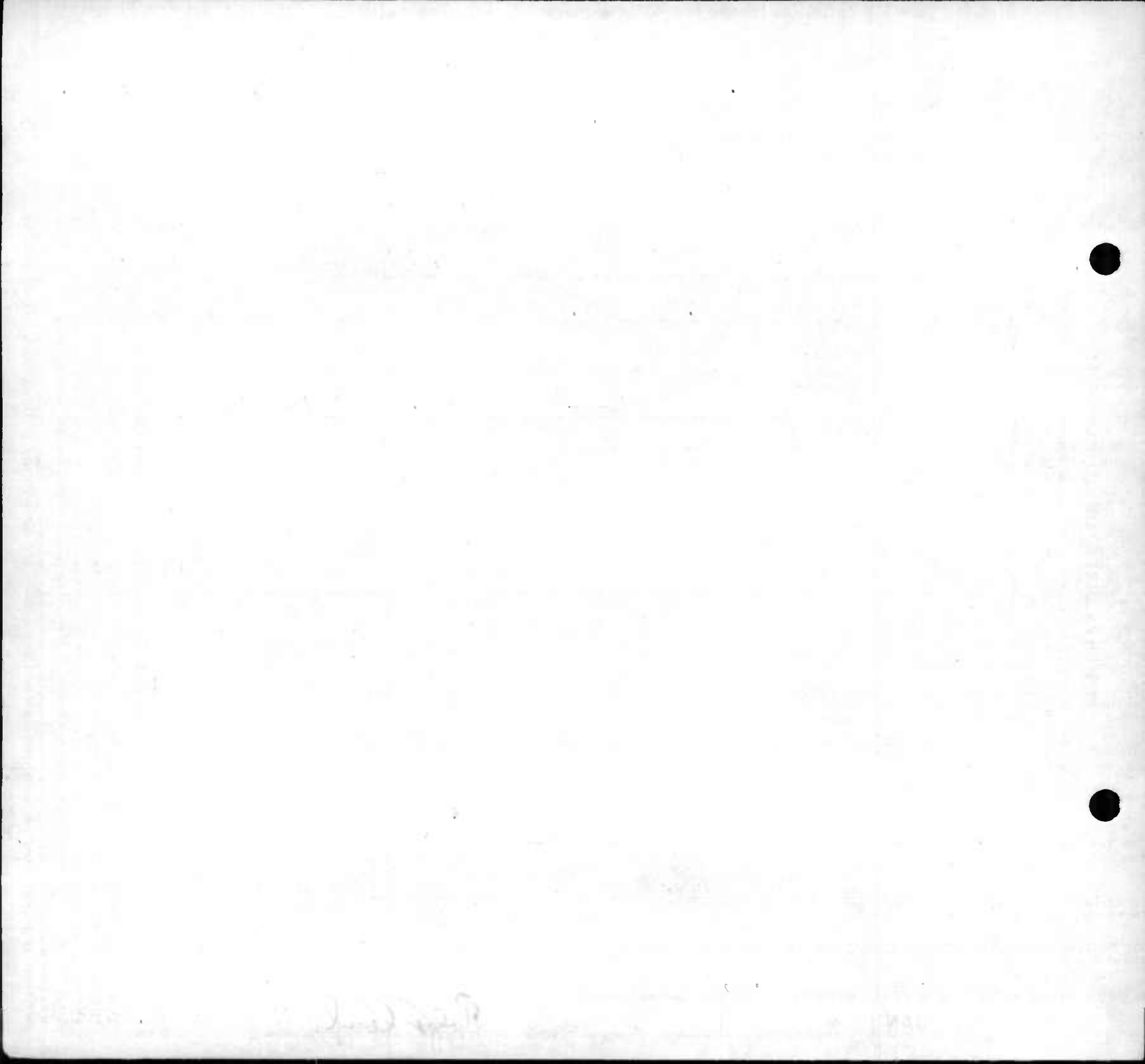
BALTIMORE CITY HEALTH DEPARTMENT									
66 00534 CERTIFICATE OF DEATH					Registered No. 66 00534				
1. NAME OF DECEASED (Type or Print) Marion Viola Dolbeare					2. DATE AND HOUR OF DEATH Jan. 17, 1966 5:45 A M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Pk. Drive & 31st Street					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Pa. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Bethlehem D. STREET ADDRESS (If rural, give location) 1030 Bridle Path Rd.				
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 6/20/18	9. AGE (In years last birthday) 47	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pa. - Bethlehem		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William Kram					14. MOTHER'S MAIDEN NAME Eva Keim				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 207-05-3251		17. INFORMANT ADDRESS Records- US PHS Hospital, Baltimore, Md.				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Massive gastrointestinal hemorrhage ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute myelogenous leukemia II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bronchopneumonia left lower lobe					INTERVAL BETWEEN ONSET AND DEATH Hours Months Days				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from Jan. 4 1966 to Jan. 17 1966 , that (I) (we) last saw the deceased alive on Jan. 17 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE  M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/17/66		
23C. PHYSICIAN'S NAME (Type) Thomas J. Lau, Surgeon (R)					23D. ADDRESS US PHS Hospital, Balto, Md.				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE Jan. 20, 66		24C. NAME OF CEMETERY or CREMATORY Memorial Park Cemetery		24D. LOCATION (City, town, or county) (State) Bethlehem, Penna.			
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1966			25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Stewart & Mowen Co., 108 W. North Av. City 1				



FUNERAL DIRECTOR: IMPORTANT

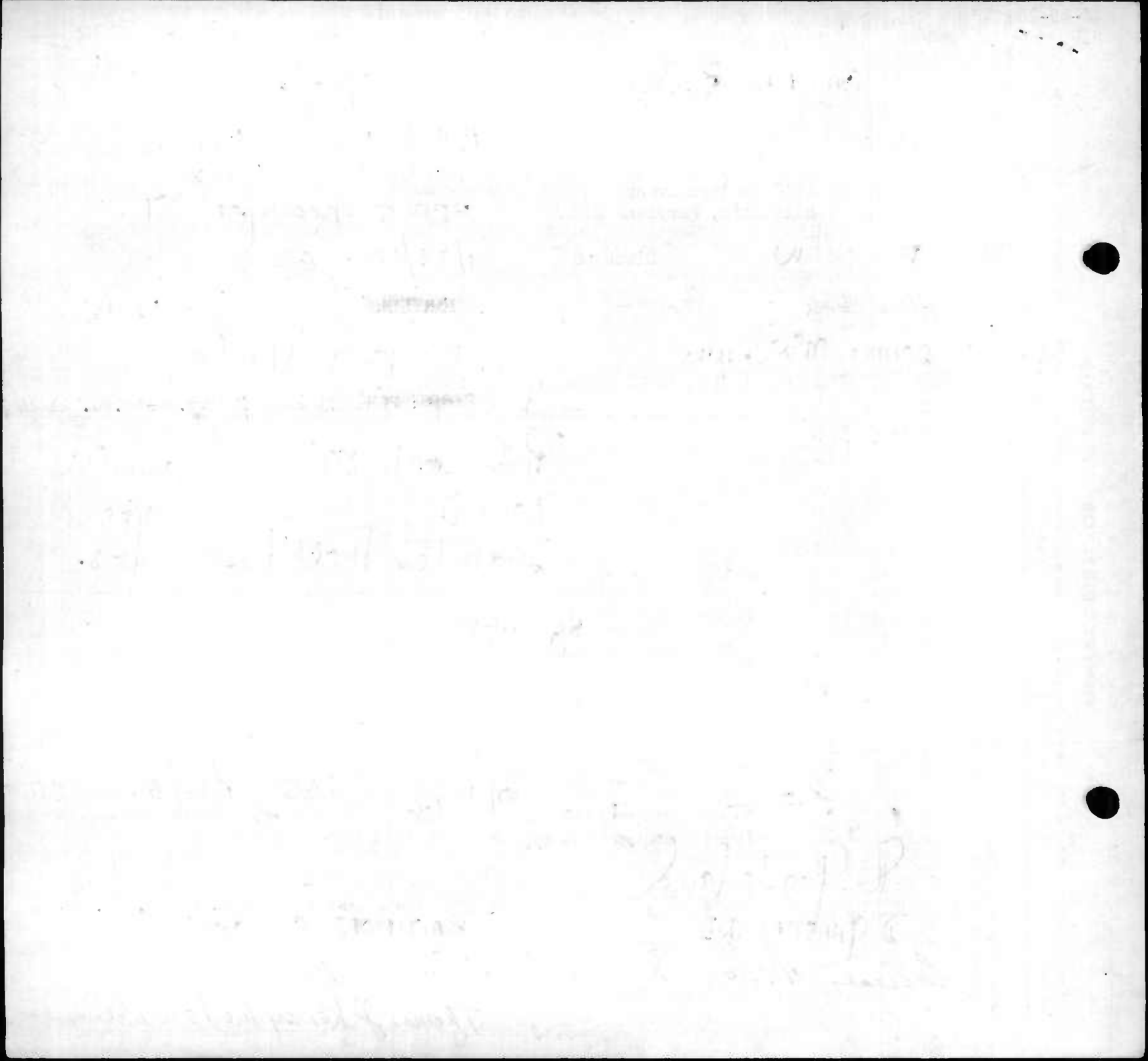
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00535		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00535	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>WILLIAM H. CONKLIN</i>		2. DATE AND HOUR OF DEATH <i>January 16, 1966</i> <i>7:40 a.</i> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Mercy Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Rural - Rosedale</i> D. STREET ADDRESS (If rural, give location) <i>1208 Hilldale Avenue</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>May 3, 1919</i>	9. AGE (In years last birthday) <i>46</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chauffeur</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>A. Hoen & Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Charles Conklin</i>		14. MOTHER'S MAIDEN NAME <i>Alice Offley</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes</i> <i>WW II</i>		16. SOCIAL SECURITY NO. <i>212-09-5356</i>		17. INFORMANT ADDRESS <i>Mary H. Conklin 1208 Hilldale Avenue 21206</i>	
18. <i>5-86 XI</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <i>Hepatic Coma (Liver failure)</i> DUE TO (B) <i>Biliary Cirrhosis of Liver</i> DUE TO (C) <i>Common bile duct obstruction 1962 - 66.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12-28-65 - 1-16-66 (about)</i> <i>Feb 63 - Jan 66</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Dec 28th</i> 1965 to <i>Jan 16th</i> 1966, that (I) (we) last saw the deceased alive on <i>1-16</i> 1966 and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Blunk atachalam</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>1-16-1966</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Jan. 19, 1966</i>		24C. NAME of CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 18 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. ...</i>		25C. FUNERAL DIRECTOR ADDRESS <i>1211 Chesaco Ave. 21206</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00536	
BIRTH NO. 66 00536		CERTIFICATE OF DEATH		1 345 P M.	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CATHERINE E. WALSH		2. DATE AND HOUR OF DEATH 1/16/66	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. AGE (In years last birthday) 63	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224		A. STATE MARYLAND B. COUNTY CITY 19-03		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21223	
D. STREET ADDRESS (If rural, give location) 328 S. Woodyear ST.		6. SEX F 7. RACE W 8. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Divorced		9. DATE OF BIRTH 1/25/02	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Mother		10B. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME DENNIS McELGOWN		14. MOTHER'S MAIDEN NAME Margaret Hurley	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Ave. Balto. Md. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO Prob. acute MI		INTERVAL BETWEEN ONSET AND DEATH minutes	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(B) DUE TO ASCVD		YRS	
		(C) Diabetes Mellitus		YRS.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		No UTI			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from 10/1/65 to 1/16/66 that it (we) last saw the deceased alive on 1/16/66 and that in (my) the opinion death occurred on the date and hour and from the causes stated above. (1) the (did) the view the body after death.		23A. SIGNATURE D. Gaasterland		23B. DATE SIGNED 1/16/66	
23C. PHYSICIAN'S NAME (Type) D. GAASTERLAND		23D. ADDRESS 4940 Eastern Avenue, Balto. Md. 21224		M.D. BALTIMORE CITY HOSP	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/19/66		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cn	
24D. LOCATION (City, town or county) Balto Md		24E. LOCATION (State)		25A. DATE REC'D BY HEALTH DEPT. JAN 18 1966	
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Thomas J. Kenny Inc 1600 Hollins St		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT															
66 00537					CERTIFICATE OF DEATH					Registered No. 66 00537					
BIRTH NO.					2. DATE AND HOUR OF DEATH										
M.E. CASE NO.					1. NAME OF DECEASED (Type or Print)					Mary H. Lauterbach					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)										
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					Md. Baltimore										
Sinai Hospital Baltimore, Md.					C. CITY OR TOWN (If outside city limits, write RURAL and give township)					Glyndon					
					D. STREET ADDRESS (If rural, give location)					8 Chatsworth Ave.					
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.			
Female		White		Widowed		Feb. 11, 1889		76							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Housewife								Balto. County, Md.				USA			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME										
Charles K. Hewes					Mary Brandenburg										
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS					
No					None					Mr. J. Edward Hewes Reisterstown, Md.					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) Coronary Infarction (B) Coronary Sclerosis (C) Hypertension					1 hour years years					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.															
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
O		✓			✓		✓			✓					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)										
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?										
✓		While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>			✓										
22. I certify that (I) (this hospital) attended the deceased from 1-15-66 to 1-16-66, that (I) (we) last saw the deceased alive on 1-16-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
23A. SIGNATURE					23B. DATE SIGNED										
James B. Saffell					1-17-66										
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS										
James B. Saffell					Reisterstown, Md.										
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county)		(State)							
Burial		1/19/66		All Saints Cemetery		Reisterstown, Md.									
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR ADDRESS								
JAN 18 1966				John E. Johnson			J. F. Eline & Sons Reisterstown, Md.								

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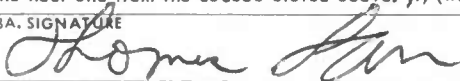
11-10-11

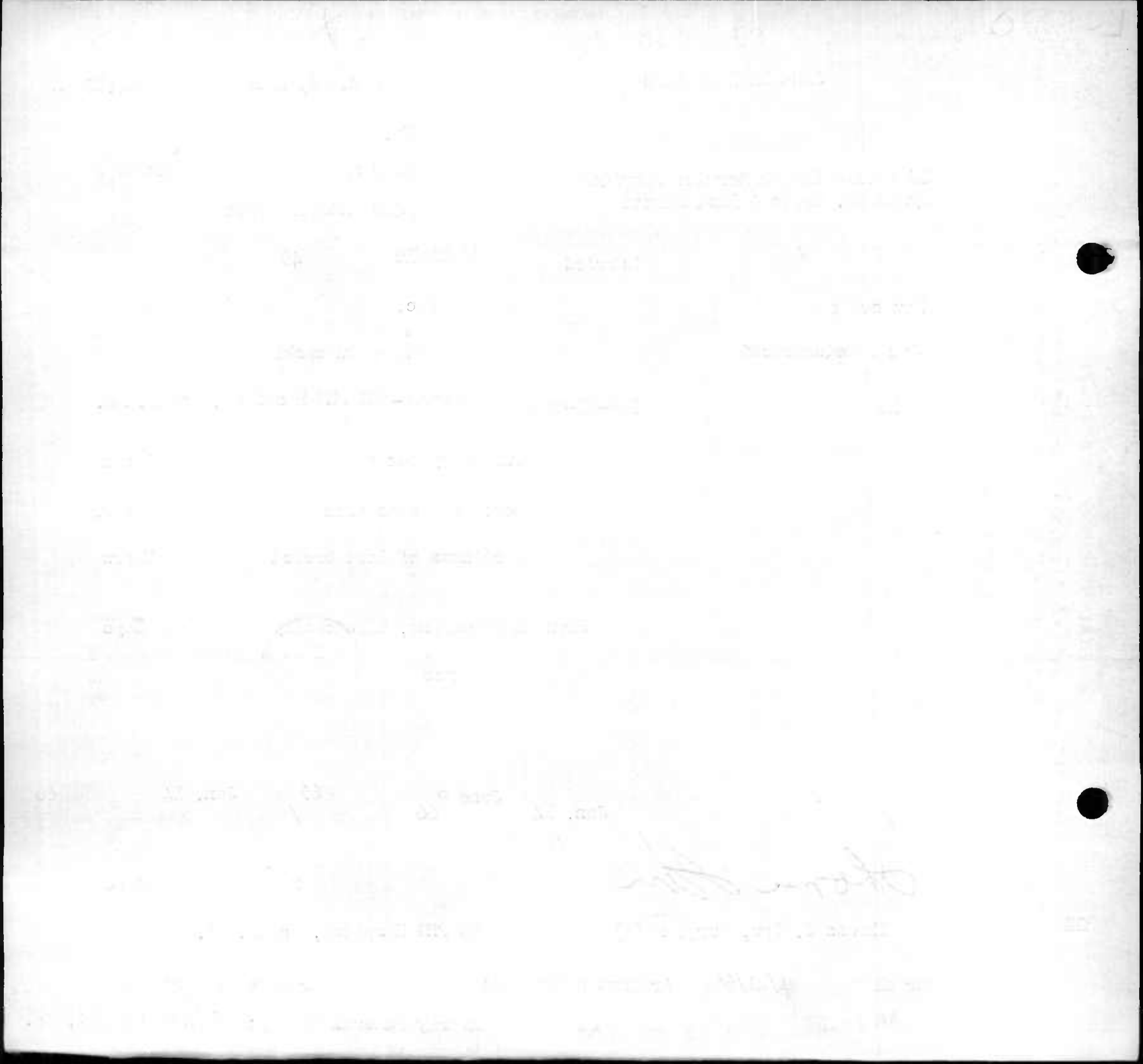
11-10-11

11-10-11

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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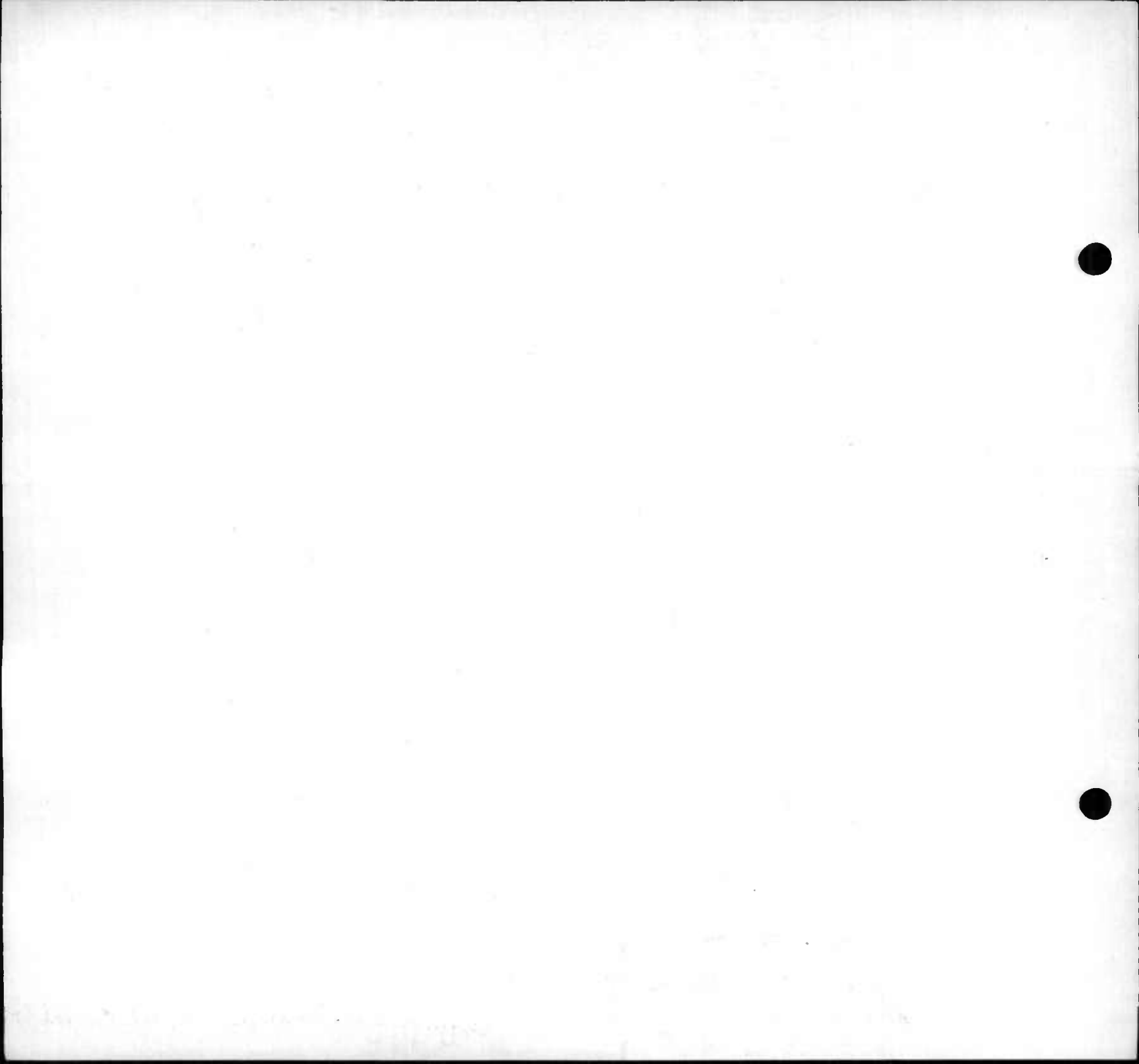
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00538	
BIRTH NO. 66 00538		CERTIFICATE OF DEATH			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) JANE BERNICE LONG		2. DATE AND HOUR OF DEATH Jan. 14, 1966		10:20 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Va. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital Wyman Pk. Drive & 31st Street		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Fairfax			
		D. STREET ADDRESS (If rural, give location) 3419 Andover Drive			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 11/27/16	9. AGE (In years last birthday) 49	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wisc.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Jacob Metuszewski		14. MOTHER'S MAIDEN NAME Bernice Guzewski	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 388-03-3511		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary edema ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebral metastases Carcinoma of left breast		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Hours Months Years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pleural effusions, bilaterally				Days	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from June 9 19 65 to Jan. 14 19 66, that (1) (we) last saw the deceased alive on Jan. 14 19 66 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 1/14/66	
23C. PHYSICIAN'S NAME (Type) Thomas J. Lau, Surgeon (R)				23D. ADDRESS US PHS Hospital, Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/21/66		24C. NAME OF CEMETERY or CREMATORY Arlington National	
24D. LOCATION (City, town, or county) (State) Arlington, Virginia		25A. DATE REC'D BY HEALTH DEPT. JAN 18 1966		25B. NAME OF REGISTRAR J. B. J. J. J.	
25C. FUNERAL DIRECTOR Everly Funeral Home		25D. ADDRESS Fairfax, Va.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 00539</u>	
BIRTH NO. <u>66 00539</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>JOHN LEROY MILLER</u>		2. DATE AND HOUR OF DEATH <u>JAN 15, 1966</u> <u>11:46 PM</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNIVERSITY HOSPITAL</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>		D. STREET ADDRESS (If rural, give location) <u>2226 CECIL AVE. 21218</u>	
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>3-31-22</u>	9. AGE (In years last birthday) <u>43</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UTILITY MAN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>JOHN DEER CO.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>LEROY M. MILLER</u>		14. MOTHER'S MAIDEN NAME <u>MARY HALL</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>218-14-9279</u>		17. INFORMANT <u>PATIENT</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>HODGKINS DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 MONTHS</u>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
21A. DATE OF OPERATION <u>4-19+4-27-65</u>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>BIOPSY</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White <input type="checkbox"/> Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>DEC 29</u> 19 <u>65</u> to <u>JAN 15</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>JAN 15</u> , 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Charles S. Harrison</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>JAN 15, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>Charles S. Harrison</u>		23D. ADDRESS <u>UNIVERSITY HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/20/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Balto. Nat. Cem.</u>	
24D. LOCATION <u>Balto. Md.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>JAN 18 1966</u>		24F. NAME OF REGISTRAR <u>Robert E. Harrison</u>	
24G. DATE REC'D BY HEALTH DEPT. <u>JAN 18 1966</u>		24H. NAME OF REGISTRAR <u>Robert E. Harrison</u>		24I. FUNERAL DIRECTOR <u>Wm. S. Harrison</u>	
24J. ADDRESS <u>1701 Mt. Callal St</u>					



45-67-94 1

NIW

66 00510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66 00510

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GUY, James W.

2. DATE AND HOUR OF DEATH

1/15/66

12:20 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

BALTIMORE CITY HOSPITALS

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)

A. STATE

B. COUNTY

MARYLAND

BALTIMORE

C. CITY OR TOWN

(If outside city limits, write RURAL and give township)

D. STREET ADDRESS

(If rural, give location)

707 Eastern Avenue, Balto. Md. 21221

5. SEX

MALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

2/20/89

9. AGE (In years
last birthday)

76

If Under 1 Yr.

Months: Days

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Capt. Balto. Co. Police Dept. (Retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

William - deceased

14. MOTHER'S MAIDEN NAME

Ellen Levina - deceased
Garrett15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

220-44-8681

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 Eastern Avenue, Balto. Md.
21224

18.

422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) DUE TO

Pneumonia

2-3 days

(B) DUE TO

Pulmonary edema

2-3 days

(C) DUE TO

ASCUD

P

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 15, 1966 to Jan 15, 1966.
that (I) (we) lost saw the deceased alive on Jan 15, 1966 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Stephen Gregg

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

January 15, 1966

23C. PHYSICIAN'S
NAME (Type)

Stephen Gregg

23D. ADDRESS

M.D.

4940 Eastern Avenue, Balto. Md. 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

1/18/66

24C. NAME OF CEMETERY or CREMATORY

Havlands Mem.

24D. LOCATION

(City, town, or county)

Balto.

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 18 1966

25B. NAME OF REGISTRAR

Robert E. Felt

25C. FUNERAL DIRECTOR

Lynell Lyons

ADDRESS

300 W. Ave. Balto. 21

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

2-5-5
Pulmonary
ASCU

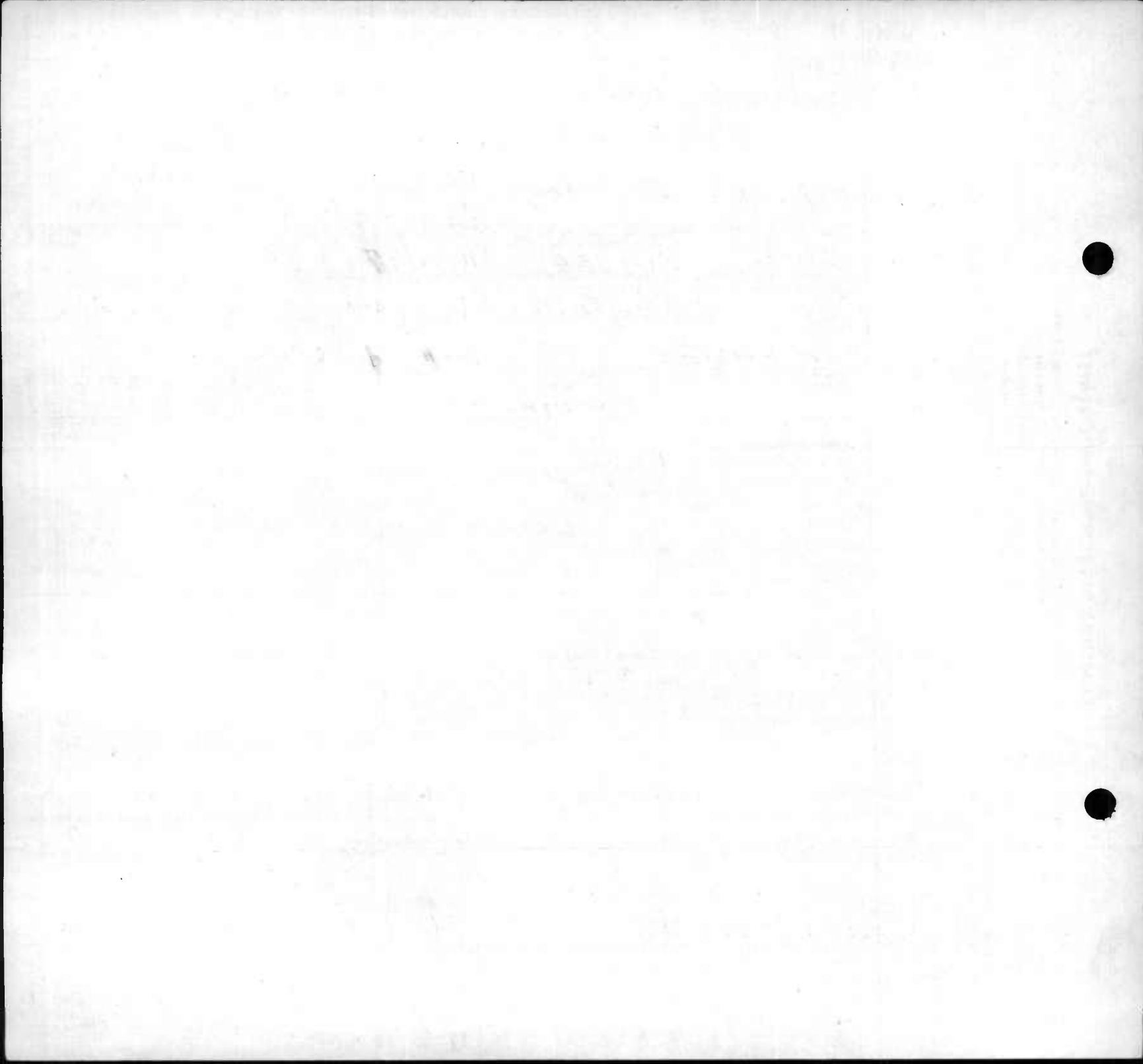
Jan 12 1952

Stephen Hagg

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00511		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 00511	
1. NAME OF DECEASED (Type or Print) Kerby, Morie Anna				2. DATE AND HOUR OF DEATH 1/16/66 4:35 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 12-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21218 D. STREET ADDRESS (If rural, give location) 3032 Guilford Ave.			
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 11/27/97	
9. AGE (In years last birthday) 68		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cashier		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dobriener, Morris		14. MOTHER'S MAIDEN NAME Berrind, Helena		15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-01-4403	
17. INFORMANT F.O. Kerby		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Terminal Ca of Transverse Colon... ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Caremmu e Chistuetim		19. ADDRESS 1044 Berkaway Beach Ave Baltimore Md. 21221		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 1/11/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Caremmu e Chistuetim		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1/6/66 at 1:30 pm to 1/16/66 at 4:30 a.m. and that (I) (we) last saw the deceased alive on 1/16/66 at 4:30 a.m. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Shelmo M. Swigert				23B. DATE SIGNED 1/16/66			
23C. PHYSICIAN'S NAME (Type) WALLEN STEIN, LEONARD				23D. ADDRESS 848 West 36th St. Balto.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/19/66		24C. NAME OF CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Harry M. Annacost		25D. ADDRESS 4204 Ridge Road Balto 15th Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>66-01283</u>		66 00512		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>66 00512</u>	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) <u>TIMOTHY ROBBINS</u>				2. DATE AND HOUR OF DEATH <u>16 JAN 1966</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>37 MERCY HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Baltimore, Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>6600 Woodbury</u> D. STREET ADDRESS (If rural, give location) <u>6300</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>12 JAN 1966</u>	9. AGE (In years last birthday) <u>—</u>	If Under 1 Yr. Months: <u>—</u> Days: <u>—</u>	If Under 24 Hrs. Hours: <u>—</u> Min.: <u>—</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT ROBBINS</u>				14. MOTHER'S MAIDEN NAME <u>FRANCES HOWARD</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT ADDRESS <u>R. ROBBINS, 6600 WOODS PKWY 21222</u>			
18. <u>73-9-3</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>MULTIPLE CONGENITAL ANOMALIES</u>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>II</u>							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>—</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>			
22. I certify that (1) (this hospital) attended the deceased from <u>1-12</u> 19 <u>66</u> to <u>1-16</u> 19 <u>66</u> , that (1) (we) last saw the deceased alive on <u>1-16</u> 19 <u>66</u> and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Perry S. Shelton</u> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1-16-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Perry S. Shelton</u>		23D. ADDRESS <u>Mercy Hospital</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-19-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>BALTIMORE NATIONAL</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 18 1966</u>		25B. NAME OF REGISTRAR <u>Perry S. Shelton</u>		25C. FUNERAL DIRECTOR <u>Yellow Springs Home</u>		ADDRESS <u>2112 Dundalk</u>	

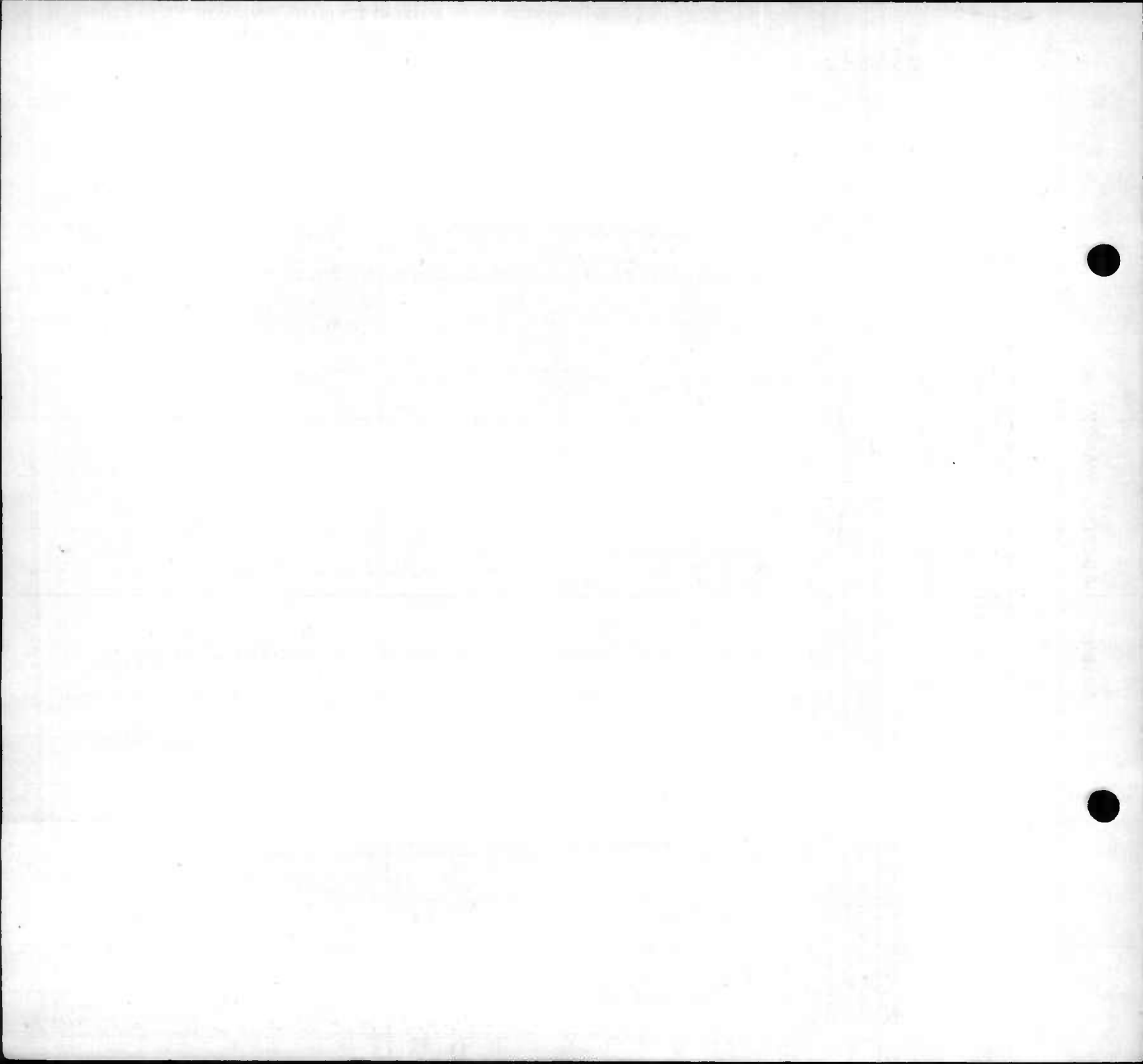
1875
— William S. ...
—
...
...

...
...
...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00543		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 00543	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HELEN MAGALINA RILEY		2. DATE AND HOUR OF DEATH 1/12/66 6 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME + HOSPITAL		4. USUAL RESIDENCE Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 26-36 D. STREET ADDRESS (If rural, give location) 6552 PARNELL AVE 21222			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 9-12-16	9. AGE (In years, last birthday) 49	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOHN ARMSTRONG		14. MOTHER'S MAIDEN NAME FRANCES NADRESKI			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 1	17. INFORMANT CHART ADDRESS		
18. 293X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) ANEMIA, CAUSE UNDETERMINED (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/7/66 19 to 1/12/66 19 C.C., that (I) (we) last saw the deceased alive on 1/12/66 19 C.C. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M.W. C. Tolentin		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/12/66	
23C. PHYSICIAN'S NAME (Type) MARLAND A. TOLENTINO		23D. ADDRESS CHURCH HOME + HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 1/14/66	24C. NAME OF CEMETERY OR CREMATORY SACRED HEART		24D. LOCATION (City, town, or county) (State) DUNDALK MD	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1966		25B. NAME OF REGISTRAR R. A. E. Johnson		25C. FUNERAL DIRECTOR ULLRICH FUNERAL HOME DUNDALK MD ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 66 00544	
66 00544 CERTIFICATE OF DEATH					
BIRTH NO.					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
George Ward Cooke		1/13/1966 12:55 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Union Memorial Hosp		Maryland 12-02			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		3100 Abell Ave			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
M	W	Single	1/29/1966	72	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Accountant		U.S. Govt.		New York	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
George Cooke (D)			Ada Barry (D)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		082-01-9962		J. Cooke Syracuse, N.Y.	
18. 420.1 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) Cardiac arrest			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		DUE TO			
ANTECEDENT CAUSES		(B) Myocardial Infarction			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO			
		(C) Anterior Artery Coronary Disease			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/3/1966 to 1/13/1966, that (I) (we) last saw the deceased alive on 1/13/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Donald G. Hall				1/13/1966	
23C. PHYSICIAN'S NAME DONALD G. HALL				23D. ADDRESS	
				M.M. UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
1-BURIAL		1-17-66		Woodlawn Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Syracuse, New York	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 18 1966				Ullrich Funeral Home Baltimore, Md.	

10. in Memorial Day 2000
11. in the same year
12. in the same year
13. in the same year
14. in the same year
15. in the same year
16. in the same year
17. in the same year
18. in the same year
19. in the same year
20. in the same year

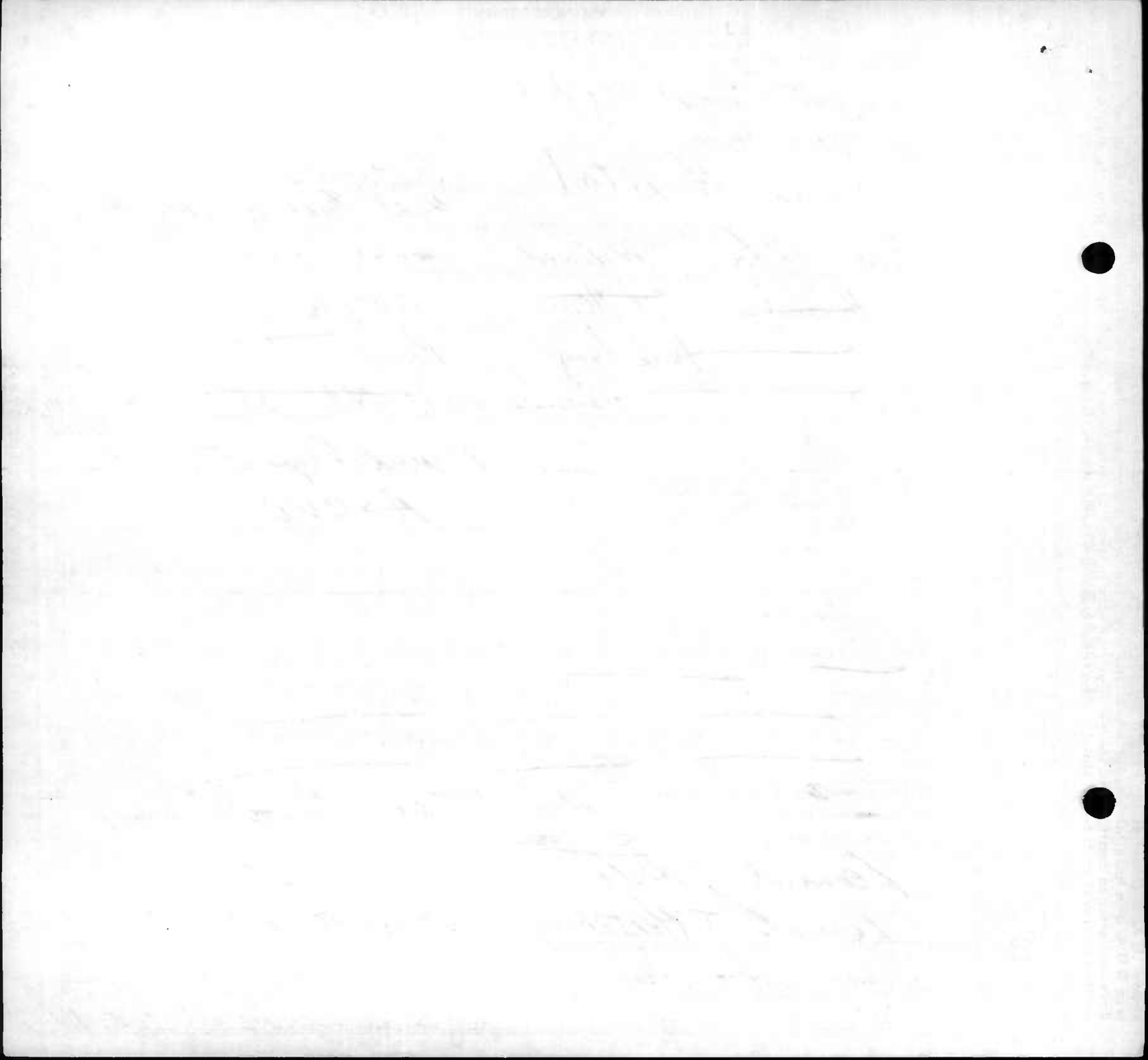
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19. in the same year
20. in the same year

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased prior to death; or (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Registered No. CG-00545

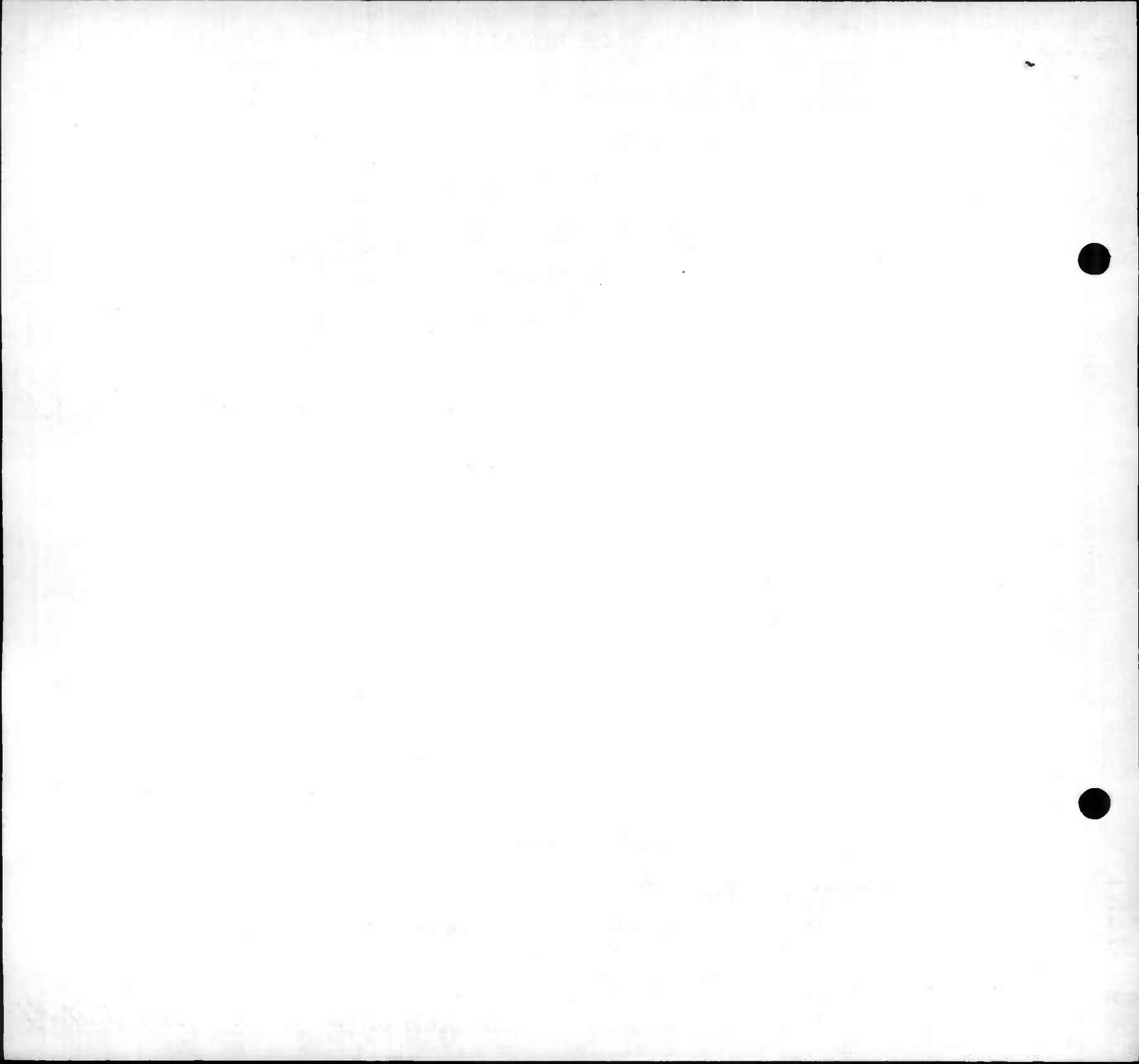
BIRTH NO.						REGISTERED NO.					
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print)						2. DATE AND HOUR OF DEATH					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)						C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
						D. STREET ADDRESS (If rural, give location)					
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 Yr. Months Days	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION						19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work Not While At Work				21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from _____ 19__ to _____ 19__ that (I) last saw the deceased alive on _____ 19__ and that in (my) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.											
23A. SIGNATURE						23B. DATE SIGNED					
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 00546					CERTIFICATE OF DEATH		Registered No. 66 00546		
BIRTH NO. 66 00546					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <i>Morris Glatt</i>					2. DATE AND HOUR OF DEATH <i>January 14/66 6 A.M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>3411 Alto Road</i>					A. STATE <i>Maryland</i> B. COUNTY <i>15-38</i>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>				
D. STREET ADDRESS (If rural, give location) <i>3411 Alto Road</i>									
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widower</i>	8. DATE OF BIRTH <i>May 15, 1871</i>	9. AGE (In years last birthday) <i>94</i>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Retail Grocery</i>	11. BIRTHPLACE (State or foreign country) <i>Lithuania</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Bernard Glatt - 3411 Alto Rd</i>			ADDRESS	
18. <i>430.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)					(A) <i>Senile Arteriosclerosis</i>				
					(B) DUE TO				
					(C) DUE TO				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>January 5, 1966</i> to <i>Jan 12, 1966</i> , that (I) (we) last saw the deceased alive on <i>Jan 12, 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Daniel J. Schwartz</i> M.D.					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <i>1/14/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Daniel Schwartz</i> M.D.					23D. ADDRESS <i>4000 W. Northern Parkway</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Jan 16/66</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Beth Tzedek</i>		24D. LOCATION (City, town, or county) (State) <i>Woodlawn, Md</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 18 1966</i>		25B. NAME OF REGISTRAR <i>Dr. J. J. ...</i>		25C. FUNERAL DIRECTOR <i>Sol ...</i>		ADDRESS <i>6000 Kent Rd.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 00547 CERTIFICATE OF DEATH					Registered No. 66 00547				
BIRTH NO. 66 00547					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) LENA JACOBS					2. DATE AND HOUR OF DEATH JANUARY 14, 1966 1:20 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-20 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3803 GLENGYLE AVENUE				
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED	8. DATE OF BIRTH 12/26/1884	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: 11 Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) LATVIA		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME MORRIS RIFKIN					14. MOTHER'S MAIDEN NAME NOAMI ?				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MR. ARNOLD L. JACOBS 3811 MENLO DRIVE				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Myocardial infarction (B) ASCVD. (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH 4 wks				
II					OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Posterior Infarction Cerebellar Artery Occlusion 6 wks				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Jan. 1957 to 1/14/66 that (I) (we) last saw the deceased alive on 1/14/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE DR. JOSEPH SHEAR					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 1/14/66	
23C. PHYSICIAN'S NAME (Type) DR. JOSEPH SHEAR					23D. ADDRESS 6715 PARK HEIGHTS AVENUE				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/16/66		24C. NAME of CEMETERY or CREMATORY MIKRO KODESH BETH ISRAEL		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1966		25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC.		25D. ADDRESS 6010 REISTERSTOWN RD			

My dear Mr. [unclear]
[unclear]

Yours truly
[unclear]

20 - 11/1/00

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11/1/00

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BALTIMORE CITY HEALTH DEPARTMENT

66 00548

BIRTH NO. 65-23576 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Vera Tate		2. DATE AND HOUR PRONOUNCED DEAD 1/14/66 12:30 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2004 Druid Hill Ave.	
5. SEX female	6. RACE colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Child	8. DATE OF BIRTH 9/11/65
9. AGE (In years last birthday) 4		10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Tate		14. MOTHER'S MAIDEN NAME Lorraine	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Miss Lorraine Tate		ADDRESS 2004 Druid Hill Ave	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Interstitial pneumonitis DUE TO INTERVAL BETWEEN ONSET AND DEATH			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. ANTECEDENT CAUSES OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <u>Werner U. Spitz</u> M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 1/14/66			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 1/18/66	
23C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		23D. LOCATION (City, town, or county) (State) Baltimore Md	
24A. DATE REC'D BY HEALTH DEPT. JAN 18 1966		24B. NAME OF REGISTRAR Robert E. Fisher	
24C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W North Av	

19660000547

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00549			
M.E. CASE NO.				CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) <i>Martha Williams</i>				2. DATE AND HOUR OF DEATH <i>1/10/66</i> <i>8 40</i> A.M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Maryland General Hospital</i> <i>827 Linden Ave. 21201</i>				A. STATE <i>Md.</i> B. COUNTY <i>17-01</i>							
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 1</i>							
				D. STREET ADDRESS (If rural, give location) <i>828 Druid Hill Ave</i>							
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>?</i>	9. AGE (In years last birthday) <i>66</i>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <i>Va</i>			
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				13. FATHER'S NAME <i>Unkn.</i>				14. MOTHER'S MAIDEN NAME <i>Unkn.</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>220-22-3793</i>				17. INFORMANT <i>Hospital Chart</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>CAUSE OF DEATH</i> <i>(A) Gangrene @ Left Foot</i> <i>(B) Traumatic Fall</i> <i>(C) Malnutrition - Marked Chronic Renal Failure</i>				INTERVAL BETWEEN ONSET AND DEATH							
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i>				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>2</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <i>Yes</i>			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Home</i>			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>828 Druid Hill Ave 21201</i>				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <i>1/2/66 AM</i>				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>			
21F. HOW DID INJURY OCCUR? <i>Pt. Fell down stairs</i>				22. I certify that (I) (this hospital) attended the deceased from <i>1/3</i> 19 <i>66</i> to <i>1/10</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>1/10</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>J. M. Steffy</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <i>1/10/66</i>			
23C. PHYSICIAN'S NAME (Type) <i>J. M. Steffy</i>				23D. ADDRESS M.D. <i>827 Linden Ave 21201</i>							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>1/18/66</i>				24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary Cemetery</i>			
24D. LOCATION (City, town, or county) (State) <i>A A County Md</i>				25A. DATE REC'D BY HEALTH DEPT. <i>JAN 18 1966</i>				25B. NAME OF REGISTRAR <i>Adolphus Halstead</i>			
25C. FUNERAL DIRECTOR <i>Adolphus Halstead</i>				25D. ADDRESS <i>1206 W North Ave</i>							

and the other side of the mountain

the mountain is very high and steep

the mountain is very high and steep

the mountain is very high and steep

the mountain is very high and steep

the mountain is very high and steep

the mountain is very high and steep

the mountain is very high and steep

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WASHINGTON

DAY

2. DATE AND HOUR PRONOUNCED DEAD

January 15, 1966

4:30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2815 W. North Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

W

8. DATE OF BIRTH

9. AGE (In years last birthday)

70

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U S A

13. FATHER'S NAME

Welford Day

14. MOTHER'S MAIDEN NAME

Martha

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mr Clifton Day 2102 W North Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

430.01
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
1/16/66

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

1/19/66

23C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cemetery

23D. LOCATION

(City, town, or county)

Baltimore Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JAN 18 1966

P. E. F. H. M.

Adolphus Halstead 1206 W North Ave

WALTER FORGE

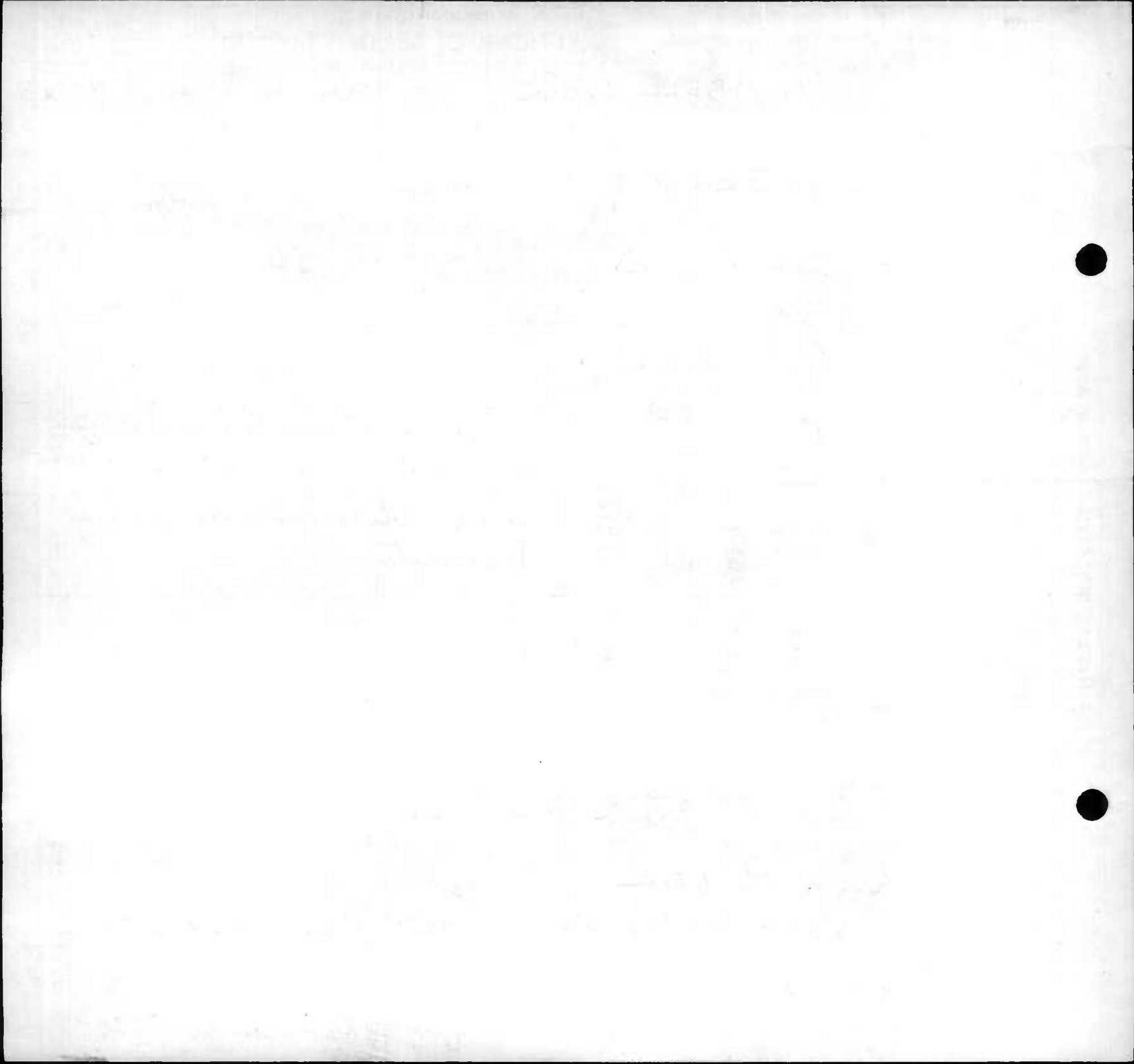
THE COMPANY

DEPT.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

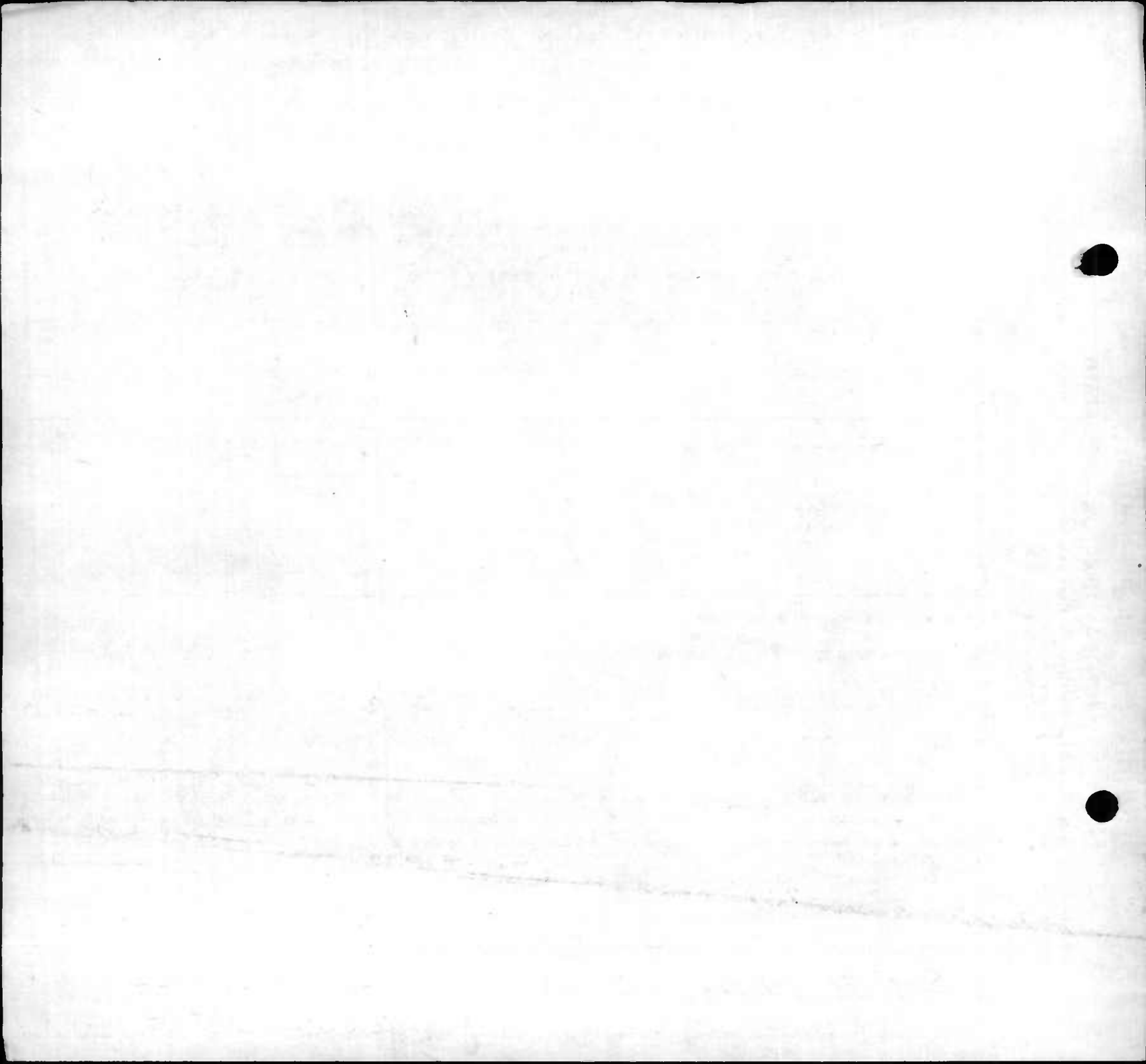
BIRTH NO. 66 00551		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 00551	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) ISABELL COOK			2. DATE AND HOUR OF DEATH JAN. 10 1966 7⁵⁵ A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1515 N. BRUCE ST			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md B. COUNTY 15-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1515 N. Bruce St		
5. SEX Fe	6. RACE Col	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 1-5-1886	9. AGE (In years last birthday) 80 ?	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ?	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Unknown		
14. MOTHER'S MAIDEN NAME Unknown			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT Mrs Fagg - 1515 N. Bruce St		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 422.1 I Myocardial Infarction			INTERVAL BETWEEN ONSET AND DEATH Dec 1965		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Myocardial Degeneration			30310		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II Serility					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-28-1965 to 1-10-1966 , that (I) (we) last saw the deceased alive on 1-10-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Geo H Pendleton				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) GEO. H. PENDLETON				23D. ADDRESS 1723 Druid Hill Ave	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-14-66		24C. NAME of CEMETERY or CREMATORY mt Calvary	
24D. LOCATION (City, town, or county) (State) Brooklyn H. A. Co md		25A. DATE REC'D BY HEALTH DEPT. JAN 18 1966			
25B. NAME OF REGISTRAR Robert E. Fagg		25C. FUNERAL DIRECTOR Fagg & Oden - Balt. Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>66 00552</u> ✓	
BIRTH NO. <u>66-004766 00552</u>							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <u>Young, Bry Boy</u>				2. DATE AND HOUR OF DEATH <u>1/15/66</u> <u>5:50 A</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital Baltimore</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>MD</u>		B. COUNTY <u>Baltimore</u>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>1802 W North Ave</u>			
5. SEX <u>M</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>1/7/66</u>	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>
					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>James Young</u>				14. MOTHER'S MAIDEN NAME <u>Marton Redford</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Christ</u>	
				ADDRESS			
18. <u>763.5 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) <u>Pneumonia</u> DUE TO		<u>10</u>	
				(B) <u>Aspiration</u> DUE TO		<u>10</u>	
				(C) <u>Pneumothorax</u>		<u>7 23/24</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<u>No</u>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>(1) (this hospital)</u> attended the deceased from <u>1/7</u> 19 <u>66</u> to <u>1-15</u> 19 <u>66</u> , that <u>(1)</u> (we) last saw the deceased alive on <u>1/15/66</u> 19 <u>66</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>H. J. Kornemann</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1/15/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>H. J. Kornemann</u>				23D. ADDRESS <u>University</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-18-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt Calvary</u>		24D. LOCATION (City, town, or county) (State) <u>Brooklyn AA md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 18 1966</u>		25B. NAME OF REGISTRAR <u>P. B. S. Johnson</u>		25C. FUNERAL DIRECTOR <u>Furnell S. Allen</u>		ADDRESS <u>Baltimore Md</u>	



BIRTH NO.

66 00553
65-25022

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 00553

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WALTER

HOLLEY, Jr.

2. DATE AND HOUR PRONOUNCED DEAD

January 15, 1966

10:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2000 Mt. Royal Terrace

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Infant

8. DATE OF BIRTH

10/10/65

9. AGE (In years
last birthday)

4x

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

4

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Walter Holley Jr.

14. MOTHER'S MAIDEN NAME

Ester

Sylvia Dorsey

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

Walter Holley Jr.

ADDRESS

Scars

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Interstitial Pneumonitis.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/16/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1-19-66

23C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cem

23D. LOCATION

(City, town, or county)

Baltimore

(State)

24A. DATE REC'D BY HEALTH DEPT.

JAN 18 1966

24B. NAME OF REGISTRAR

Robert E. Feltz, M.D.

24C. FUNERAL DIRECTOR

Elroy O. Wilson, 1000 B Street

ADDRESS

WALLACE & GORDON

WASHINGTON

USA

7

PI

43-6 7-36 1B

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66 00554

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Ned Smith

2. DATE AND HOUR OF DEATH

1-16-66

10:45 p.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

12 Cottage Avenue - #21222

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

3-5-01

9. AGE (In years
last birthday)

64

If Under 1 Yr.

Months: Days

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Ed Smith

14. MOTHER'S MAIDEN NAME

Lara Smith

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS-BCH-4940 Eastern Avenue

18. 422.1 I + 260X
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

Gram Negative sepsis

INTERVAL BETWEEN
ONSET AND DEATH

24 hours

(B) DUE TO

Gangrene Oleg

2 weeks

(C) DUE TO

ASCVD

years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Diabetes mellitus

years

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-23 19 65 to 1-16- 19 66,
that (I) (we) last saw the deceased alive on 1-16 19 66 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Laurice McAfee M.D.

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

1-16-66

23C. PHYSICIAN'S
NAME (Type)

Dr. Laurice McAfee

M.D.

23D. ADDRESS

BCH-4940 Eastern Avenue, Baltimore, Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial

1-21-66

Mt Calvary Cent

Brooklyn

Md

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

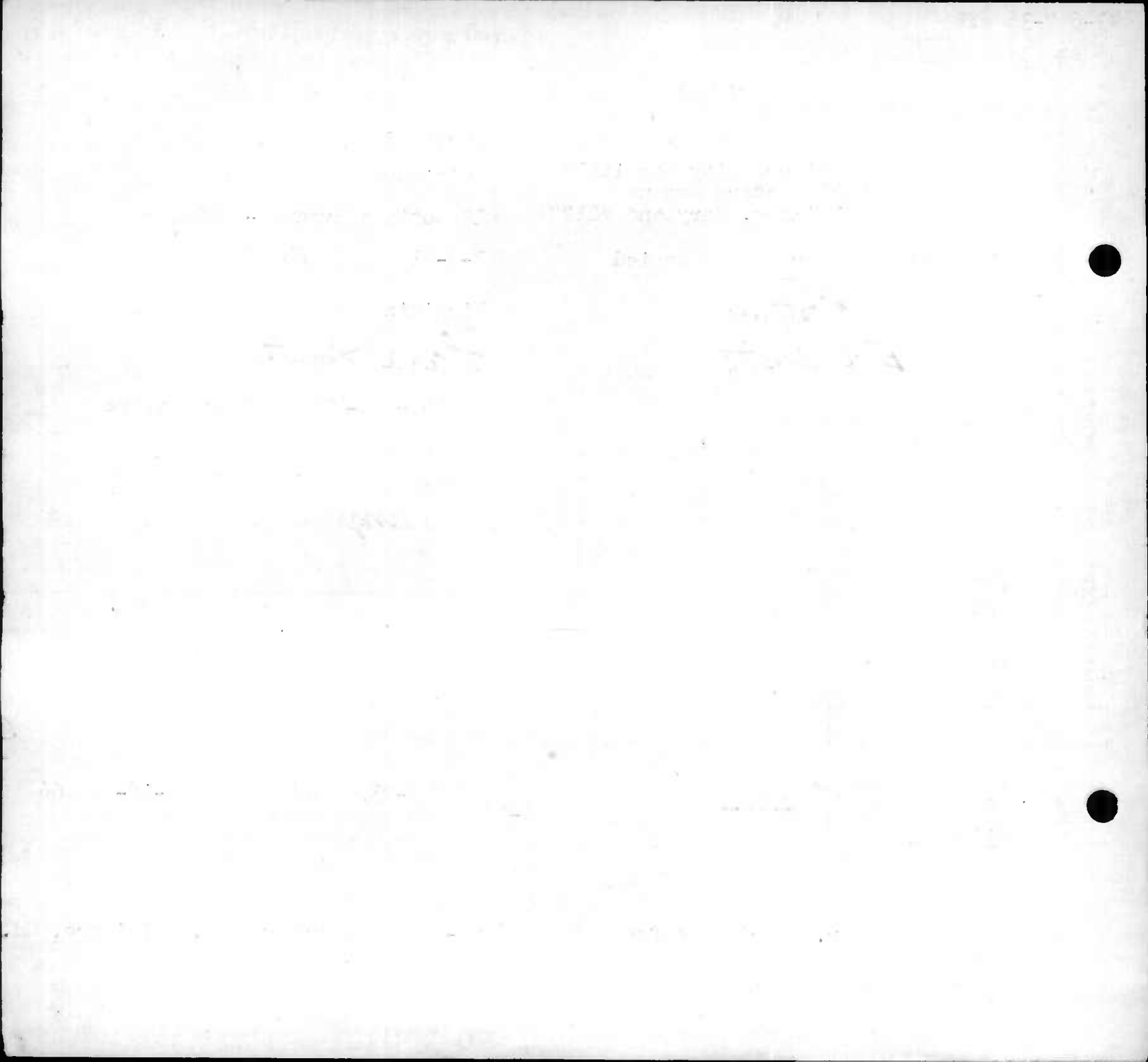
JAN 18 1966

Robert E. Taylor

Chas. L. Wilson 1000 Bunting Ave

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



B. 650

66 00555

BALTIMORE CITY HEALTH DEPARTMENT

66 00555

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED
(Type or Print)

LILLIAN M. BRUNE

2. DATE AND HOUR PRONOUNCED DEAD

1-16-66

12:15 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

3443 KENYON AVENUE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3443 Kenyon Avenue 21213

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

August 24, 1917

9. AGE (In years
last birthday)

48

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.

4 23

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Jacob J. Fiersuk

14. MOTHER'S MAIDEN NAME

Catherine Kozla

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

213-19-9905

17. INFORMANT

ADDRESS

Mr. John F. Brune 3443 Kenyon Ave - 13

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot wound of head
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, steel, office bldg.,
etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

3443 Kenyon Avenue

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day)

approx. 12:00
1 16 '66 Noon

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot self in head

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

Russell S. Fisher

M.D.

EXAMINER'S NAME (Type)

Russell S. Fisher, M. D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-17-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Jan-20-66

23C. NAME of CEMETERY or CREMATORY

Holy Redeemer

23D. LOCATION

(City, town, or county)

(State)

4430 Belair Rd - Baltimore Md.

24A. DATE REC'D BY HEALTH DEPT.

JAN 18 1966

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

John A. Grebliauskas, 604 S. Milton Ave

ADDRESS

VALLEY FORTS

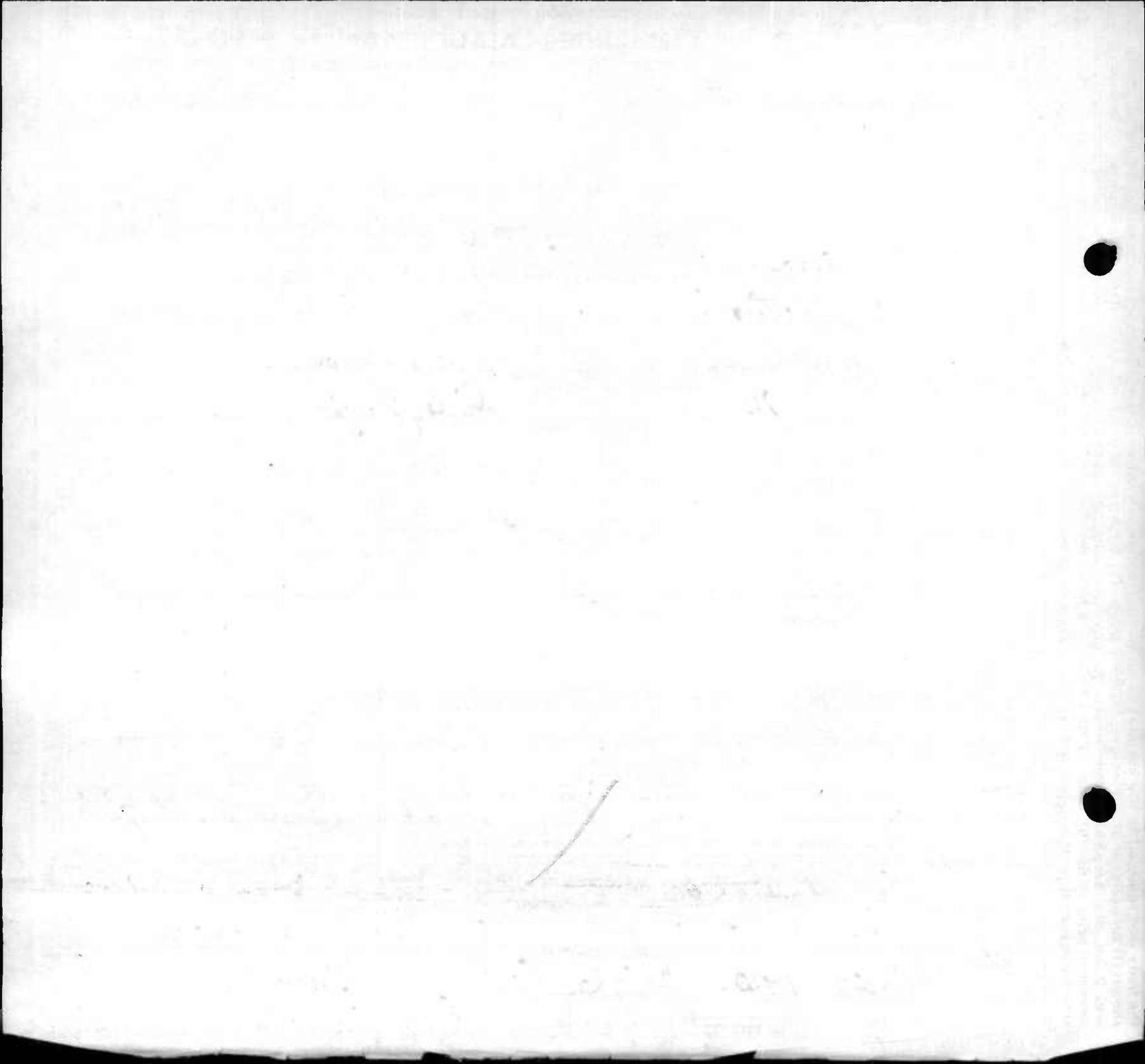
PAGE 10

10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		66 00556		66 00556	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <i>BARNES, Paul</i>		2. DATE AND HOUR OF DEATH <i>1-17-66 4:30 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bon Secours Hospital</i>		A. STATE <i>Maryland</i> B. COUNTY <i>20-01</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>1916 W. Fayette St.</i>			
5. SEX <i>M</i>	6. RACE <i>Colored</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Never Married</i>	8. DATE OF BIRTH <i>7-15-1886</i>	9. AGE (In years last birthday) <i>79</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Reluctant</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Delaware</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		13. FATHER'S NAME <i>unknown</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Shirley Wright</i>	
18. <i>420.1 I</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		(A) <i>Coronary Heart Failure</i> DUE TO <i>Acute myocardial infarction</i>		<i>unknown</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>ASCTD</i> DUE TO		<i>unknown</i>	
(C)					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <i>N</i> (this hospital) attended the deceased from <i>1-16-1966</i> to <i>1-17-1966</i> , that <i>N</i> (we) last saw the deceased alive on <i>1-17-1966</i> and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <i>We</i> (did) <i>did not</i> view the body after death.					
23A. SIGNATURE <i>Samuel C. Chu</i>				23B. DATE SIGNED <i>1-17-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>SAMUEL C. CHUO</i>				23D. ADDRESS <i>Bon Secours Hospital, Baltimore, Md</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Buried</i>		24B. DATE <i>1-20-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>McMahon Cem</i>	
24D. LOCATION (City, town, or county) (State) <i>Brooklyn Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 18 1966</i>		25B. NAME OF REGISTRAR <i>Paul E. Fisher</i>	
25C. FUNERAL DIRECTOR <i>Chas. O. Wilson</i>		25D. ADDRESS <i>1000 Beant...</i>			

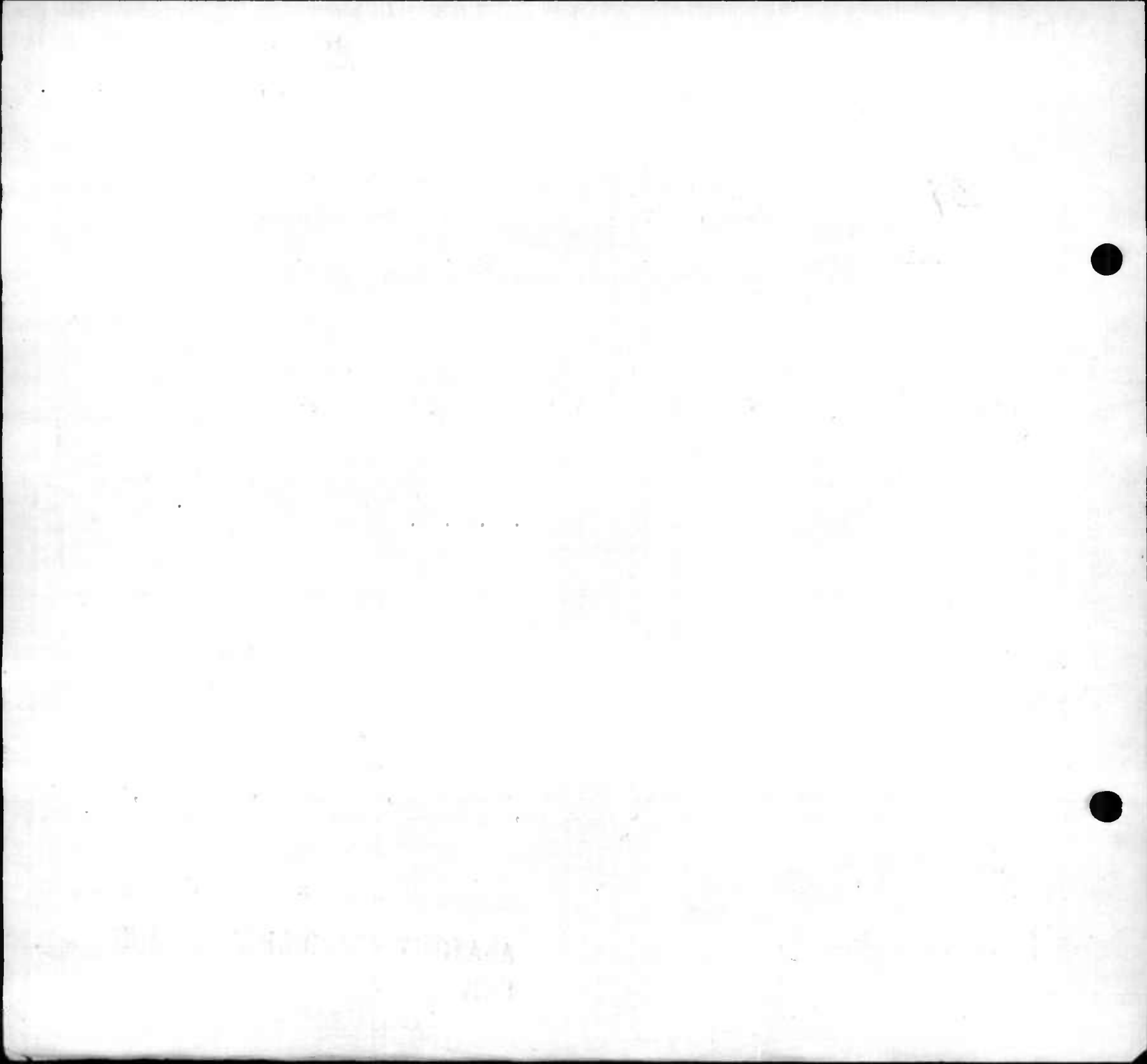


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00557	
BIRTH NO. 66 00557		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) George Styl		2. DATE AND HOUR OF DEATH January 12, 1966 5:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 1416 Greene Street Unknown	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) ?	8. DATE OF BIRTH 60?	9. AGE (In years last birthday) 60?	10. If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Unknown	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cerebral Hemorrhage DUE TO (B) H. C. V. D. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 12, 1966 to January 12, 1966, that (I) (we) last saw the deceased alive on January 12, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Andre Rigaud		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED January 12, 1966	
23C. PHYSICIAN'S NAME (Type) Andre Rigaud		23D. ADDRESS 1514 Division Street		M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) JAN 17 1966		24B. DATE		24C. NAME OF CEMETERY or CREMATOR (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1966		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				66 00558	
CERTIFICATE OF DEATH				Registered No. 66 00558	
BIRTH NO. 66 00558					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <i>Martha Crosby</i>		2. DATE AND HOUR OF DEATH <i>January 15-66 2 P. M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Provident Hospital</i>		A. STATE <i>Maryland</i> B. COUNTY <i>13-01</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>2406 Callow Ave</i>			
5. SEX <i>F</i>	6. RACE <i>Col</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>12-8-1907</i>	9. AGE (In years last birthday) <i>58</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>	
13. FATHER'S NAME <i>Joe Cook</i>		14. MOTHER'S MAIDEN NAME <i>Frances Cook</i>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Robert Crosby 2406 Callow Ave</i>	
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <i>Inter-stitial Nephritis</i> (B) DUE TO <i>Diabetes Mellitus</i> (C) DUE TO <i>Hypertensive C.V. D.</i> <i>Secondary Anemic</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1963</i> <i>1963</i> <i>1963</i> <i>1964</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5-3-1963</i> to <i>Jan 13 1966</i> , that (I) (we) last saw the deceased alive on <i>Jan 15 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>T.D. Phifer</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>1/17/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>1228 N. Caroline St.</i>		23D. ADDRESS <i>T.D. Phifer</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-19-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Memorial Park Balt Co. Md</i>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 12 1966</i>			
25B. NAME OF REGISTRAR <i>Robert Crosby</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Fayner Sanders 2176 Preston St</i>			

Dear Sir,
I have the honor to acknowledge
the receipt of your letter of the 15th
inst.

15th inst.

Yours very truly,
J. H. [illegible]

Yours

[illegible]

[illegible]

[illegible]

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

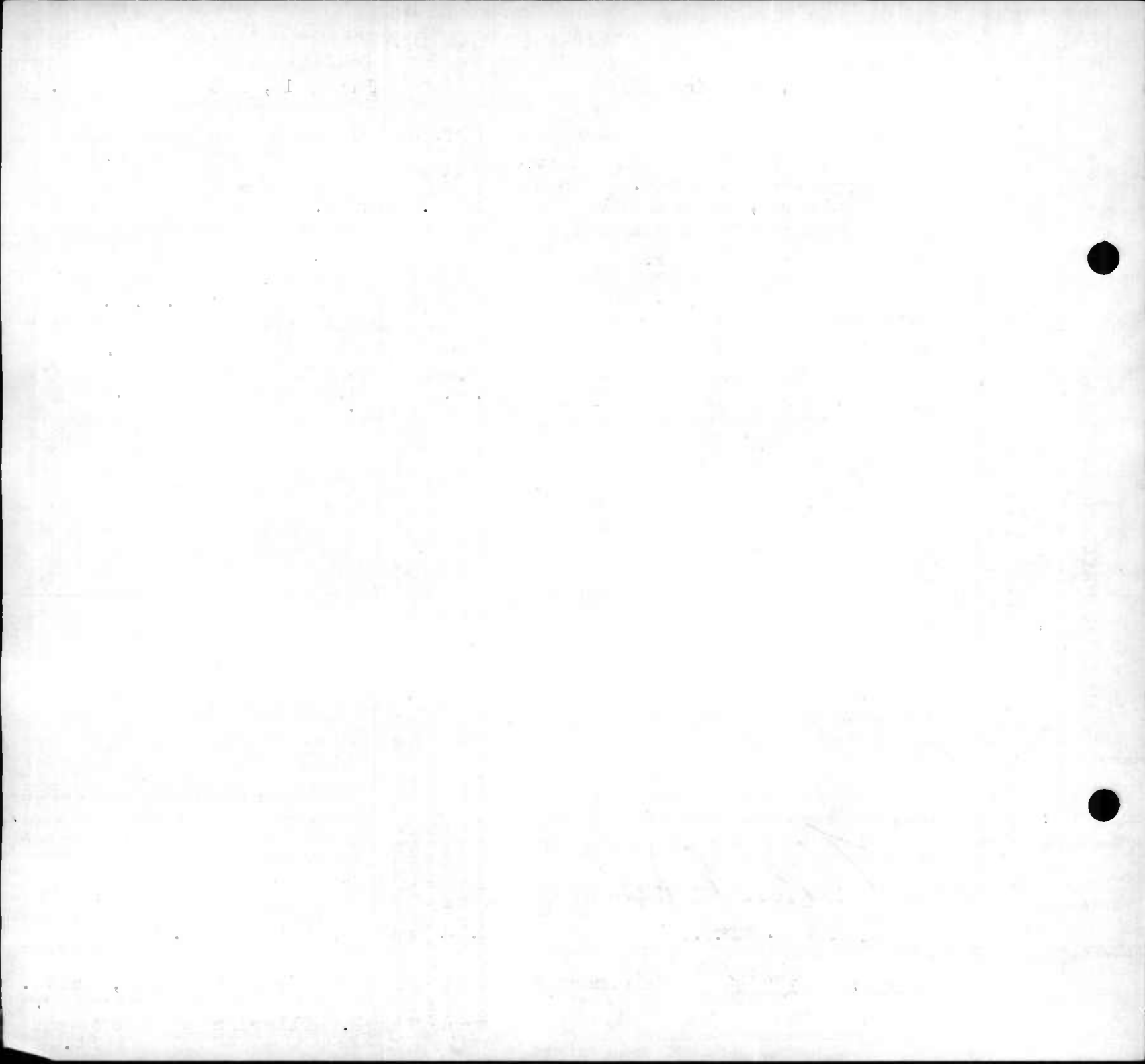
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00559	
BIRTH NO. 66 00559		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CHARLES EDWARD FREY		2. DATE AND HOUR OF DEATH JANUARY 16, 1966 4:25 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY HOWARD			
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL WILKEN & CATON AVENUE BALTIMORE, MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		D. STREET ADDRESS (If rural, give location) 206 N ROGERS AVENUE	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 9-22-84	9. AGE (In years lost birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME HENRY FREY		14. MOTHER'S MAIDEN NAME MICHA RIDGELY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-09-6257		17. INFORMANT ST. AGNES HOSPITAL RECORDS	
18. 428.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO <i>Acute myocardial infarction</i> (B) DUE TO <i>Pneumonia</i> (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 5		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that XX (this hospital) attended the deceased from 1-15 19 66 to 1-16 19 66 , that X (we) last saw the deceased alive on 1-16 19 66 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. XX (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Rafael Marin</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/16/66	
23C. PHYSICIAN'S NAME (Type) RAFAEL MARIN		23D. ADDRESS M.D. <i>St Agnes Hosp</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-20-1966		24C. NAME of CEMETERY or CREMATORY St. Johns	
24D. LOCATION (City, town, or county) (State) Ellicott City, Md		25A. DATE REC'D BY HEALTH DEPT. JAN 18 1966		25B. NAME OF REGISTRAR <i>R. E. Johnson</i>	
25C. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md		ADDRESS			

THE UNIVERSITY OF CHICAGO
DIVISION OF THE PHYSICAL SCIENCES
DEPARTMENT OF CHEMISTRY
LABORATORY OF ORGANIC CHEMISTRY
530 SOUTH EAST ASIAN AVENUE
CHICAGO, ILLINOIS 60607
U.S.A.
TEL: 312/937-1234
FAX: 312/937-1234
E-MAIL: CHEM@CHICAGO.EDU
WWW: WWW.CHEM.CU.EDU

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

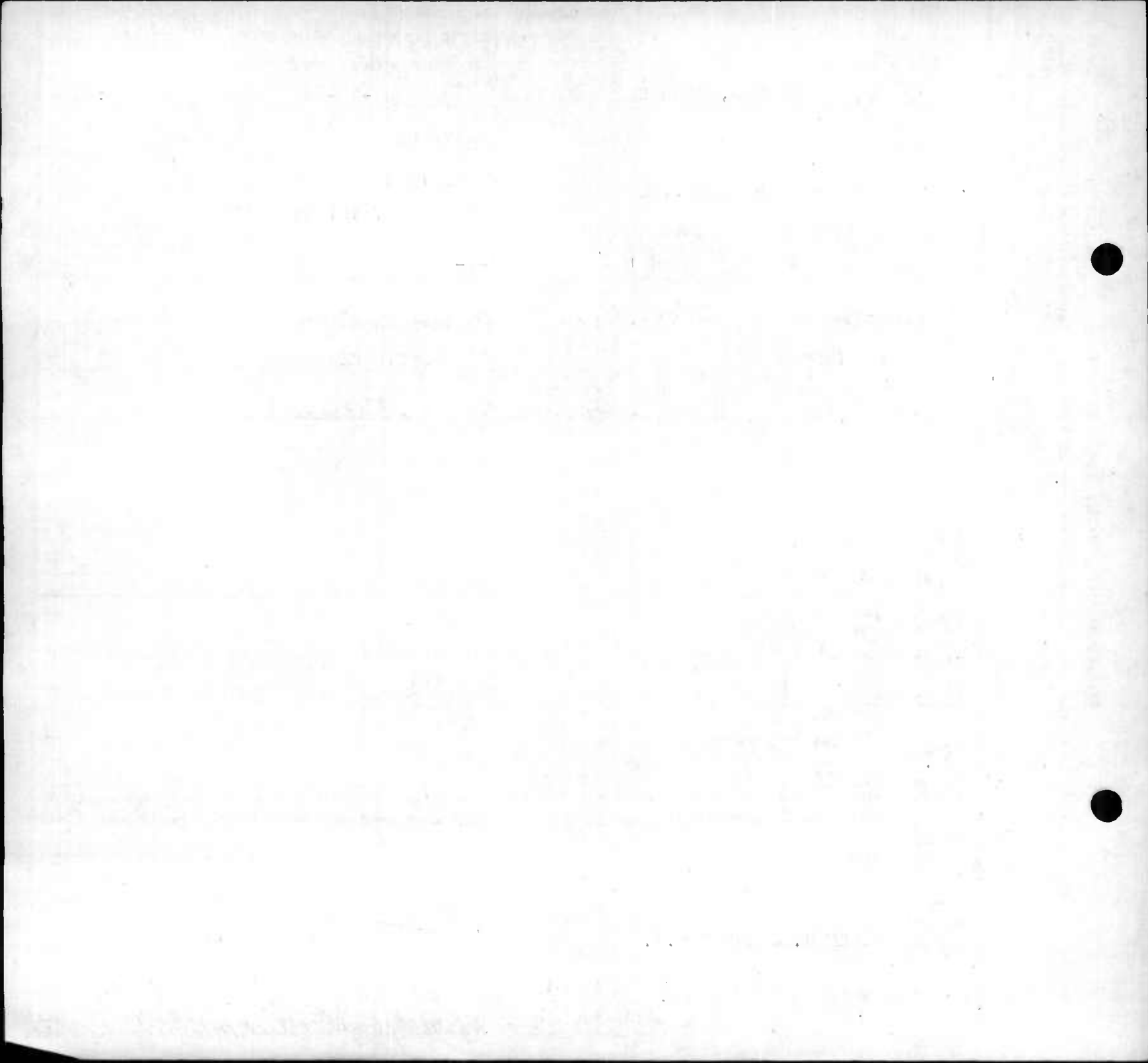
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66-00560	
BIRTH NO. 66 00560				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) GUNTHER, Frederick (NMI)				January 16, 1966 9:00 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218				A. STATE Maryland B. COUNTY Baltimore	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
				D. STREET ADDRESS (If rural, give location) 200 S. Eaton St.	
5. SEX Male	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 11/29/1900	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Ooys: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sander		10B. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Gunther			14. MOTHER'S MAIDEN NAME Kathryn Armond		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 10/9/42 to 3/26/43			16. SOCIAL SECURITY NO. 217-32-9506		
17. INFORMANT Records V. A. Hospital, 3900 Loch Raven Blvd. Baltimore, Md. 21218			ADDRESS		
18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Carcinoma of lung DUE TO INTERVAL BETWEEN ONSET AND DEATH 5 years					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that X (this hospital) attended the deceased from December 27, 1965 to January 16, 1966 , that 01 (we) last saw the deceased alive on January 16, 1966 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. X (We) (did) XXX view the body after death.					
23A. SIGNATURE <i>Frederic B. Askins</i>				23B. DATE SIGNED January 17, 1966	
23C. PHYSICIAN'S NAME (Type) FREDERIC ASKINS, M.D.				23D. ADDRESS V. A. Hospital, Baltimore, Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/20/66		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery Frederick Road, Balto.	
24D. LOCATION Frederick Road, Balto.		24E. (City, town, or county)		24F. (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1966		25B. NAME OF REGISTRAR R. L. G. E. G. E.		25C. FUNERAL DIRECTOR Frederick D. Miller Inc 3019 Monument St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. 66 00561	
BIRTH NO. 66 00561					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) THOMAS, JOHN L		2. DATE AND HOUR OF DEATH 1-15-66 3:10 AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 8-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 21 05 EAST OLIVER STREET			
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7-9-02	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10B. KIND OF BUSINESS OR INDUSTRY Steel Co.		11. BIRTHPLACE (State or foreign country) Windsor Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JAMES THOMAS			
14. MOTHER'S MAIDEN NAME COUNCIL Lee Cora Lee		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 217-01-4028		17. INFORMANT ADDRESS Luellen Thomas 2105 E. Oliver St.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 330X1		(A) SUB ARACHNOID HEMORRHAGE DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) ? HYPERTENSION DUE TO		(C) ?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 1/12 19 66 to 1/15 19 66 , that (1) (we) last saw the deceased alive on 1/15 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Allen Johnson		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/15/66	
23C. PHYSICIAN'S NAME (Type) ALLEN D. JOHNSON M.D.		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-19-66		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) Anne Arundel Co. Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 18 1966			
25B. NAME OF REGISTRAR R. L. B. E. E. E.		25C. FUNERAL DIRECTOR ADDRESS Randolph J. Collick 1412 E. Preston St.			

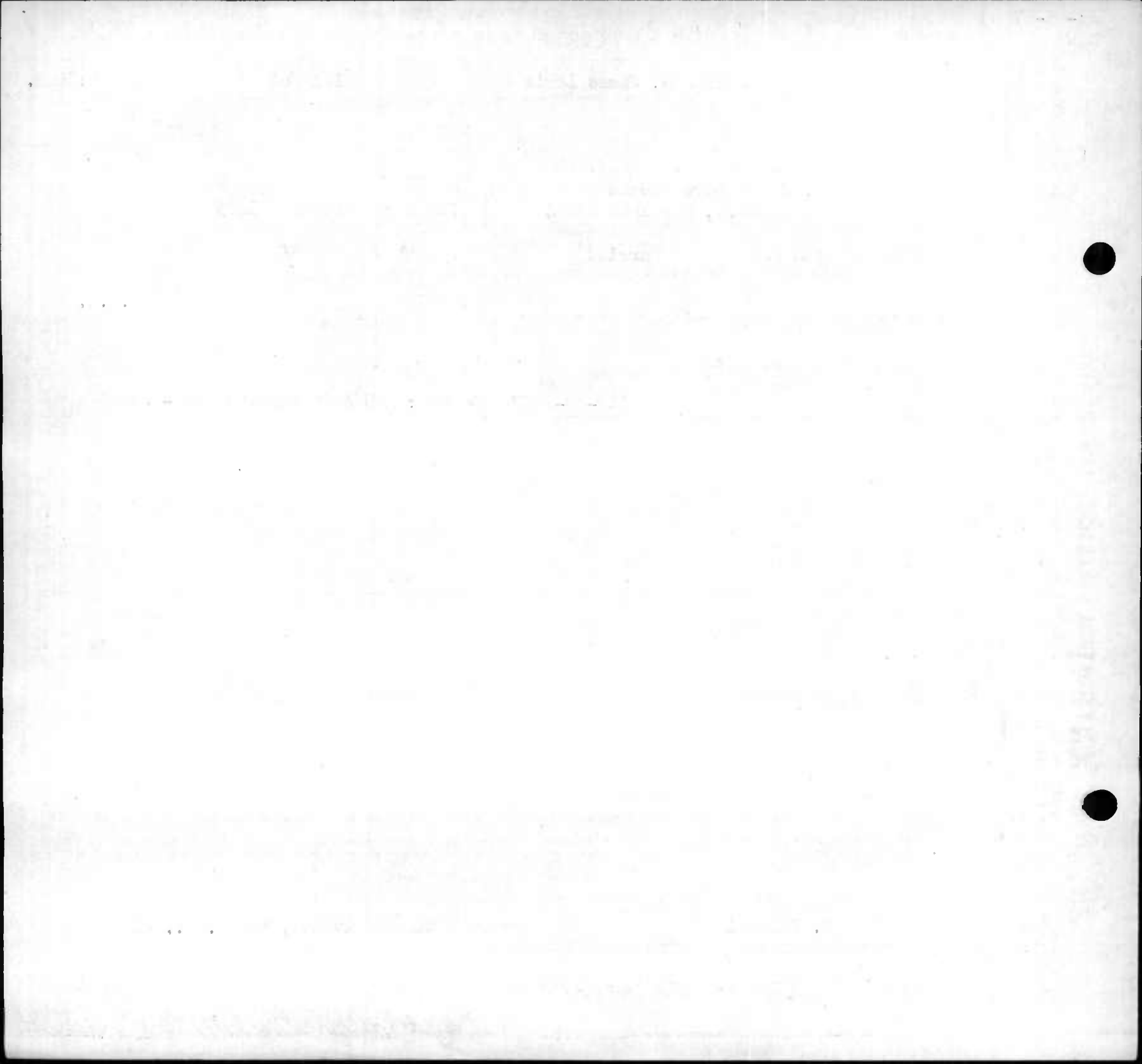


43-05-87
NIW

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-536 BIRTH NO.		66 00562		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00562	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
SAUNDERS, James Lewis				1/13/66		9:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224				MARYLAND 8-03			
5. SEX MALE				6. RACE NEGRO		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	
8. DATE OF BIRTH 7/9/11				9. AGE (In years last birthday) 54		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Longshoreman				Steam Ship Co.		VIRGINIA	
13. FATHER'S NAME Charles Saunders				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 218-18-3637		17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Ave - 21205	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION CAUSING IT. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Zoster, Quadruplegia				CAUSE OF DEATH (A) DUE TO Multiple myeloma (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs.	
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-7-65 to 1-13-66 and that (I) (we) last saw the deceased alive on 1-13-66 9 AM and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE V. Felitti				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1-13-66	
23C. PHYSICIAN'S NAME (Type) V. Felitti				23D. ADDRESS M.D. 4940 Eastern Avenue, Balto. Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1-16-66		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Arbutus, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1966		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Rudolph J. Collick		25D. ADDRESS 1412 E. Preston St.	

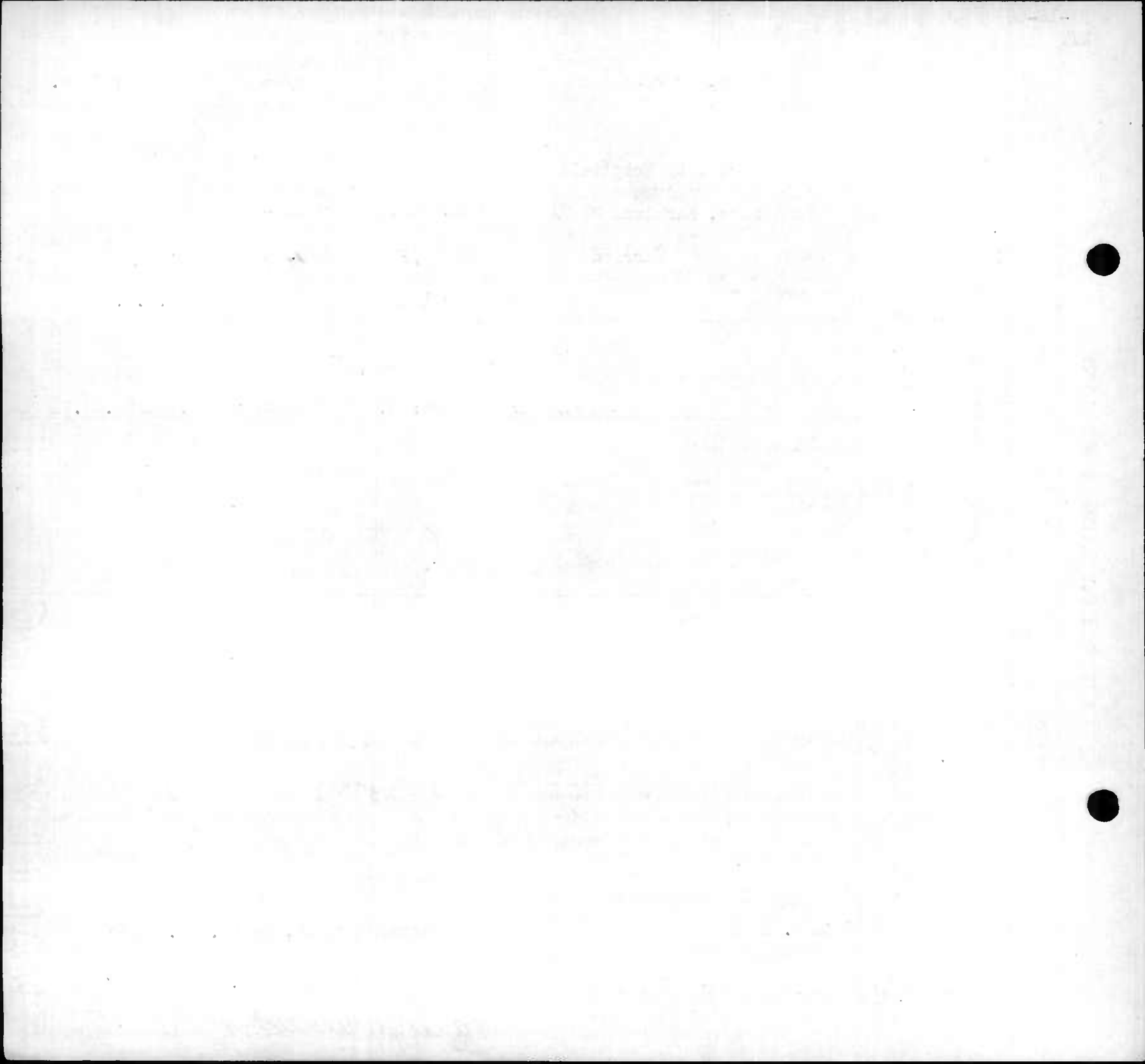


37-18-68 |
NW

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00563	
5-3722		66 00563		CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				STOKES, Henry Lee	
2. DATE AND HOUR OF DEATH		1/15/66		3:45 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE	
				MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
Baltimore City Hospitals		4940 Eastern Avenue		BALTIMORE	
Baltimore, Maryland 21224		D. STREET ADDRESS (If rural, give location)		4940 Eastern Avenue - 21224	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days
Male	Negro	Married	8/26/18	47	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer		Steel Co.		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
		Pearl Stokes		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		236-22-4574		RECORDS: BCH 4940 Eastern Ave., Balto. Md. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) acute myocardial infarction		20 minutes	
ANTECEDENT CAUSES		(B) generalized atherosclerosis		year	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Diabetes mellitus		year	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-25 1964 to 1-15 1966, that (I) (we) last saw the deceased alive on 1-15 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED	
		John R. Burton		1-15-66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
John R. Burton		4940 Eastern Avenue, Balto. Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1-19-66		Mt. Calvary Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 18 1966		Robert E. Johnson		Rudolph J. Collick	
				14126 E. Preston St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00564		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 00564	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>Bailey Vernon</u>			2. DATE AND HOUR OF DEATH <u>Jan 13, 1966</u> <u>5 15</u> A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Baltimore Maryland</u> B. COUNTY <u>Baltimore City</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>18-02 1060 West Vine St.</u>		
5. SEX <u>M</u>	6. RACE <u>C</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widower</u>	8. DATE OF BIRTH <u>2/14/00</u>	9. AGE (In years last birthday) <u>65</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>	
13. FATHER'S NAME <u>William</u>			14. MOTHER'S MAIDEN NAME <u>Rachel ? Wootsile</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>21 801 6798</u>	17. INFORMANT <u>Son</u> ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>162.1 I</u> <u>Bronchogenic Carcinoma</u>			CAUSE OF DEATH (A) <u>Bronchogenic Carcinoma</u> DUE TO (B) <u>2 weeks (Known)</u> DUE TO (C) <u>—</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Chronic Renal Failure</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 11</u> 19 <u>66</u> to <u>Jan 12</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Jan 13</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Harold C. Standiford</u> M.D.				23B. DATE SIGNED <u>1/13/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Harold C. Standiford</u>				23D. ADDRESS <u>—</u> M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-17-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Calvary</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 18 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>Barrie V. Gouper</u> ADDRESS <u>512 N. Carrollton Ave.</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 00565		CERTIFICATE OF DEATH				Registered No. 66 00565			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) IDA R. CHATHAM				2. DATE AND HOUR OF DEATH 1-15-66 6:20 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MONTEBELLO STATE HOS P.						A. STATE MD. B. COUNTY ANNE ARUNDEL			
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) GLEN BURNIE 5200			
						D. STREET ADDRESS (If rural, give location) Box 159-A, NABBS CREEK			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 7-13-05	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME OSCAR ROELEXKE						14. MOTHER'S MAIDEN NAME HILDE BRANDT			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 219-03-4304		17. INFORMANT ADDRESS HOSPITAL RECORDS			
18. 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CEREBRAL THROMBOSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 4 MOS.						INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. HYPERTENSION									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (H) (this hospital) attended the deceased from 1-6-65 to 1-15-66 , that (H) (we) lost saw the deceased alive on 1-15-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Irving L. Cooperstein						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-15-65	
23C. PHYSICIAN'S NAME (Type) Irving L. Cooperstein M.D.						23D. ADDRESS MONTEBELLO STATE HOSPITAL, BALTO. MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/19/66		24C. NAME OF CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1966		25B. NAME OF REGISTRAR R. L. Fink		25C. FUNERAL DIRECTOR Raymond C. Fink		ADDRESS Glen Burnie, Md.			

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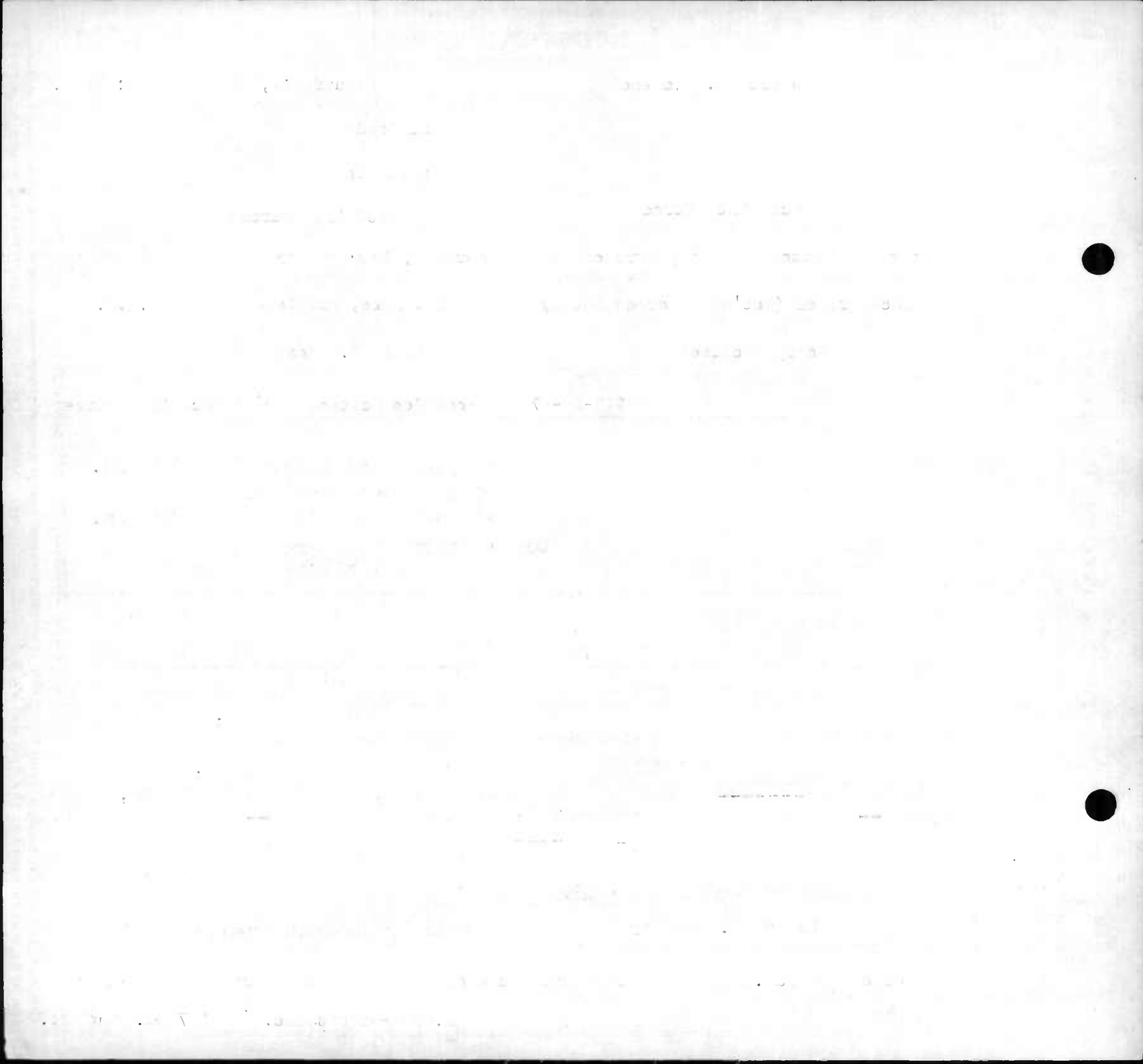
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						Registered No. 66 00566	
CERTIFICATE OF DEATH							
BIRTH NO. 66 00566		M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) August J. Beitzel				2. DATE AND HOUR OF DEATH January 14, 1966 6:00 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 12-03	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				D. STREET ADDRESS (If rural, give location) 441 East 25th Street			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH April 4, 1900	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver (Ret'd)		10B. KIND OF BUSINESS OR INDUSTRY Jarman Motors		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Beitzel				14. MOTHER'S MAIDEN NAME Emma N. Bean			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-09-4704		17. INFORMANT Beatrice Beitzel			
				ADDRESS 441 East 25th Street (180)			
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) Acute myocardial infarction		10 min.	
				(B) Arteriosclerotic cardiovascular disease		10 yrs.	
				(C) Old myocardial infarction (1959)			
MEDICAL CERTIFICATION				19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
				20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from November 4, 1965 to January 14, 1966 , that (I) (we) last saw the deceased alive on January 7, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Lloyd E. Saylor				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/15/66	
23C. PHYSICIAN'S NAME (Type) Lloyd E. Saylor				23D. ADDRESS 3902 Greenmount Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan. 18, 66		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1966		25B. NAME OF REGISTRAR Robert E. Saylor		25C. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc.		ADDRESS 1217 St. Paul St.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LILLIAN M. MOORE

2. DATE AND HOUR PRONOUNCED DEAD

January 15, 1966

1:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1307 W. Baltimore Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Never Married

8. DATE OF BIRTH

July 29, 1896

9. AGE (In years
lost birthday)

69

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Self Employed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

(Unknown) Moore

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218-28-4523

17. INFORMANT

Florence E. Merrick

ADDRESS

1307 W. Baltimore St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORKNOT WHILE
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/16/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Jan. 18, 1966

23C. NAME of CEMETERY or CREMATORY

Loudon Park Cemetery

23D. LOCATION

Baltimore

(City, town, or county)

(State)

Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JAN 18 1966

Wm. Cook-Brooks, Inc.

1217 St. Paul St.

WALTER FORCE

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 00568</u>	
BIRTH NO. <u>66 00568</u>		CERTIFICATE OF DEATH		M.	
1. NAME OF DECEASED (Type or Print) <u>Lillian Milburn</u>			2. DATE AND HOUR OF DEATH <u>January 13, 1966</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u> <u>Redwood & Green Streets</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>6-01</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>906 Harlem Ave.</u>		
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec. 15, 1889</u>	9. AGE (In years last birthday) <u>76</u>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>William Moss</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>(Mrs.) Geraldine Smith</u> ADDRESS <u>906 Harlem Ave.</u>	
18. <u>443X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>HYPERTENSIVE CARDIO- VASCULAR DISEASE</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <u>ONE YEAR</u>			INTERVAL BETWEEN ONSET AND DEATH <u>ONE YEAR</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>OCT. 18</u> 19 <u>65</u> to <u>JAN. 13</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>JAN. 13</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Carlton L. Sexton</u>				23B. DATE SIGNED <u>JAN. 14, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>CARLTON L. SEXTON</u>			23D. ADDRESS <u>819 PARK AVE., BALTIMORE, MD.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-17-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Balto. National Cemetary</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 18 1966</u>		25B. NAME OF REGISTRAR <u>R. A. 2, 1966</u>		25C. FUNERAL DIRECTOR <u>Arlington S. Phillips</u> ADDRESS <u>1727 N. Monroe St.</u>	

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BIRTH NO. 66 00569				BALTIMORE CITY HEALTH DEPARTMENT				MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 00569			
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print)				Cromwell MABLE R. GRyce				2. DATE AND HOUR PRONOUNCED DEAD January 15, 1966 10:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 725 Rosedale Street				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-06 D. STREET ADDRESS (If rural, give location) 725 Rosedale Street							
5. SEX Female		6. RACE Negro		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 8/12/1909		9. AGE (In years last birthday) 56		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Levin Mason				14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 217.16.1203		17. INFORMANT Carolyn Fenwick				ADDRESS 3335 Winterbourn	
18. I 443 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) Hypertensive Cardiovascular Disease. DUE TO (B) DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Petty M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Petty, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1/16/66											
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 1/20/66		23C. NAME OF CEMETERY or CREMATORY Crown Mt. Pl. Laurel				23D. LOCATION (City, town, or county) (State) Md.			
24A. DATE REC'D BY HEALTH DEPT. JAN 18 1966				24B. NAME OF REGISTRAR D. H. Jones		24C. FUNERAL DIRECTOR Wilmington Phillips		ADDRESS 1727 N. Monroe St.			

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Machine Dept
J. M. Mearns

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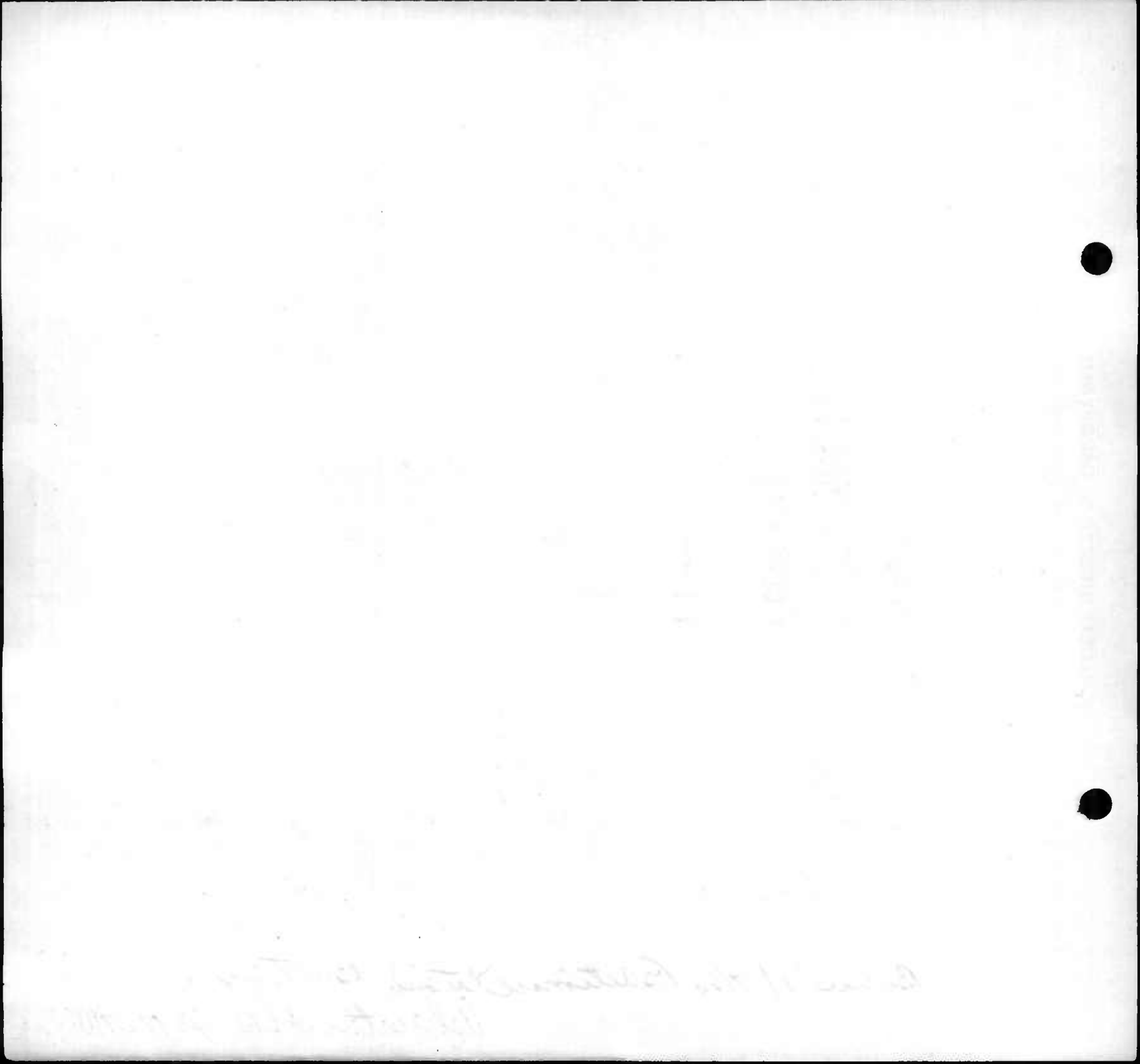
Revised 1/20/10 General Mearns, J. M.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

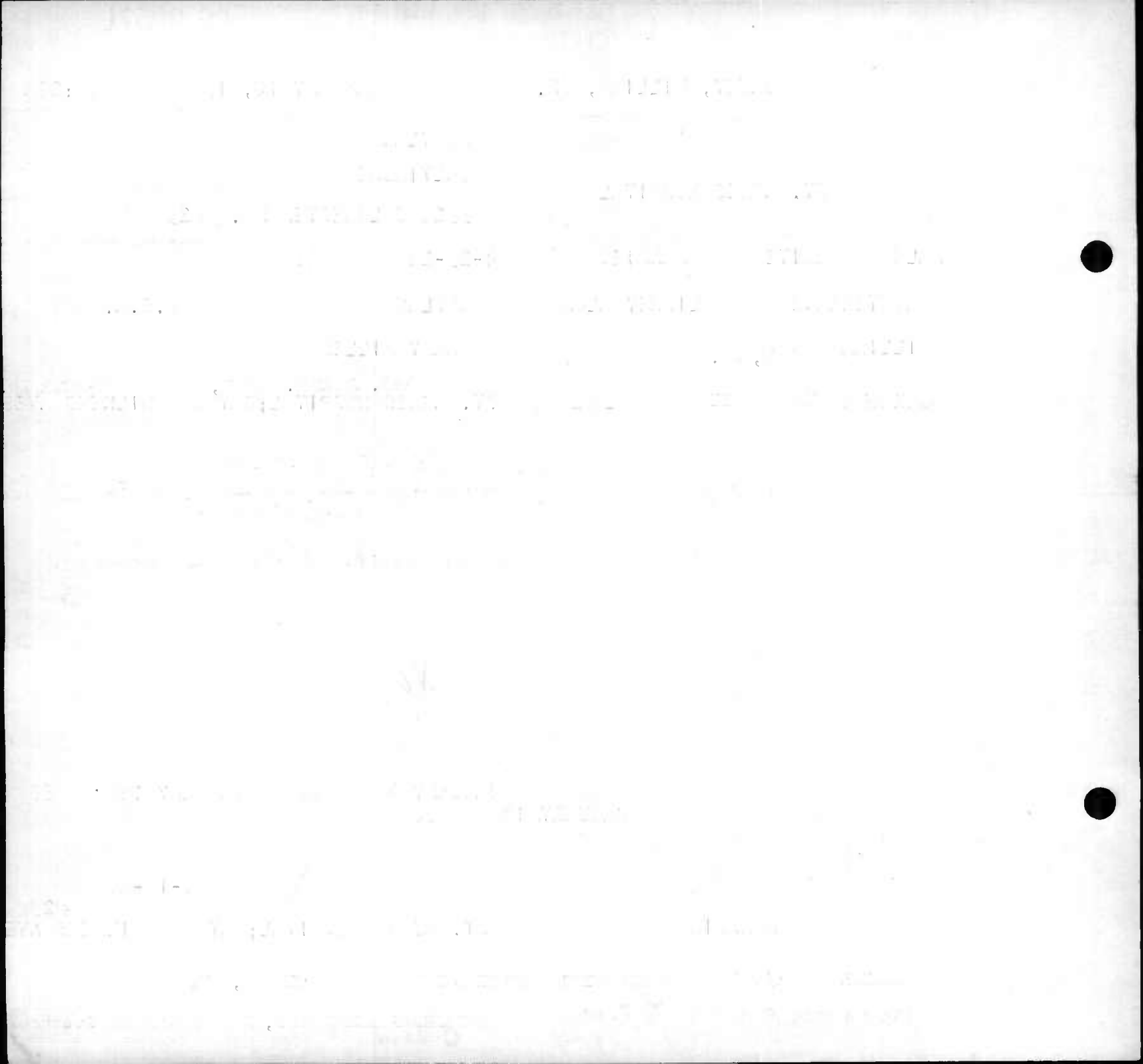
BIRTH NO. 66-08165 66 00570				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00570	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Baby Roy Stanley</i>				2. DATE AND HOUR OF DEATH <i>1.13.1966 2³⁰ A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Bon Secours Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>15-02</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE 21217</i> D. STREET ADDRESS (If rural, give location) <i>1821 BAKER STREET</i>			
5. SEX <i>M</i>	6. RACE <i>NEGRO</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>INFANT</i>	8. DATE OF BIRTH <i>1-7-66</i>		9. AGE (In years last birthday) <i>7</i>	If Under 1 Yr. If Under 24 Hrs. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>IRA Stanley</i>				14. MOTHER'S MAIDEN NAME <i>Mabel WINTERS</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>CHART (IRA Stanley 1821 BAKER ST.)</i>			
18. <i>762.51</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Premature baby - 1.7.1966 to -</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Primary pulmonary atelectasis 1.13.1966</i>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Subarachnoid hemorrhage, bica.</i>							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>1.7.1966</i> to <i>1.13.1966</i> , that (I) (we) last saw the deceased alive on <i>1.12.1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Mr. Boomer</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>1.13.1966</i>	
23C. PHYSICIAN'S NAME (Type) <i>Boomer</i>				23D. ADDRESS <i>Bon Secours Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/17/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore National</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore MD</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 18 1966</i>		25B. NAME OF REGISTRAR <i>Re. H. E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Washington Phillips</i>		ADDRESS <i>1727 N. Mount St.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00571				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00571	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) CAVEY, WILLIAM, JR.				2. DATE AND HOUR OF DEATH JANUARY 14, 1966 10:20A.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF INSTITUTION ST. AGNES HOSPITAL		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY 25-41	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 3920 COLCHESTER RD. #29			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4-25-24	9. AGE (In years last birthday) 41	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE		10B. KIND OF BUSINESS OR INDUSTRY LISKEY ALUM		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM CAVEY, SR.				14. MOTHER'S MAIDEN NAME MARY MILLER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) XXXXXXXXXX YES WW II		16. SOCIAL SECURITY NO. 216-16-1867		17. INFORMANT MRS. JEAN M. CAVEY, 3920 COLCHESTER RD. ST. AGNES HOSPITAL; CATON & WILKENS AVES			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I Acute myocardial infarction diastolic infarction ventricular fibrillation				INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JANUARY 4 19 66 to JANUARY 14 19 66, that (I) (we) last saw the deceased alive on JANUARY 14 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>R. Marin</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-14-66	
23C. PHYSICIAN'S NAME (Type) R MARIN				23D. ADDRESS ST. AGNES HOSPITAL; CATON & WILKENS AVE #29			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/18/66		24C. NAME of CEMETERY or CREMATORY MEADOWRIDGE MEMORIAL PARK		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1966		25B. NAME OF REGISTRAR R. E. F. F.		25C. FUNERAL DIRECTOR HUBBARD, FUNERAL HOME, 4107 Wilkens Avenue		ADDRESS 21229	



1
5432

66 00572

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 00572

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

PHILLIP SCHULTHEIS

2. DATE AND HOUR PRONOUNCED DEAD

January 15, 1966 1:30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

2430 Annor Court 21230

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2430 Annor Court 21230

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

1/1/1881

9. AGE (In years
last birthday)

84 85

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

MECHANIC

10B. KIND OF BUSINESS OR INDUSTRY

RETIRED

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

217-01-3402
XXX-XXX XXXX

17. INFORMANT

ADDRESS

MRS. GRACE C. SCHULTHEIS, 2430 ANNOR CT. # 30

18.

420.0 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED
1/16/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

1/18/66

23C. NAME of CEMETERY or CREMATORY

LOUDON PARK CEMETERY

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE, MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JAN 18 1966

Robert E. Fadden

HUBBARD FUNERAL HOME, 4107 WILKENS AVE. # 29

WILLIAM F. BERGE

REG. CO. 100TH

USA

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH											
BIRTH NO. 66 00573		Registered No. 66 00573									
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		DORSEY CHARLES R, SR.		2. DATE AND HOUR OF DEATH		JAN 14 1966		2:55P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL						A. STATE MD					
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) ELKRIDGE					
D. STREET ADDRESS (If rural, give location) BOX 267 WASHINGTON BLVD.						5. SEX MALE					
						6. RACE WHITE					
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED						8. DATE OF BIRTH 2-3-11		9. AGE (In years last birthday) 54		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC				10B. KIND OF BUSINESS OR INDUSTRY SELF		11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL DORSEY						14. MOTHER'S MAIDEN NAME OLIE DUNKERLEY					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 217-01-9320		17. INFORMANT MRS. HELEN T. DORSEY, WASH. BLVD. BOX 267 ST AGNES HOSPITAL CATON & WILKENS AVE.					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.						CAUSE OF DEATH Multiple metastasis due to Squamous cell carcinoma Rt lung					
						INTERVAL BETWEEN ONSET AND DEATH					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diffuse myocardial damage						19A. DATE OF OPERATION 07-14-65					
						19B. CONDITION FOR WHICH OPERATION WAS PERFORMED cc of lung Rt					
20A. AUTOPSY? (Yes or No) none						20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from DEC 27 19 65 to JAN 14 19 66, that (I) (we) last saw the deceased alive on JAN 14 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>Al Archana</i>						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 1-14-66	
23C. PHYSICIAN'S NAME (Type) Al Archana						23D. ADDRESS M.D. CATON & WILKENS AVENUE					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/18/66		24C. NAME of CEMETERY or CREMATORY MEADOWRIDGE MEMORIAL PARK				24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1966				25B. NAME OF REGISTRAR Robert E. Taylor				25C. FUNERAL DIRECTOR ADDRESS HUBBARD FUNERAL HOME, 4107 WILKENS AVE. # 29			

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P. # 100-100000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

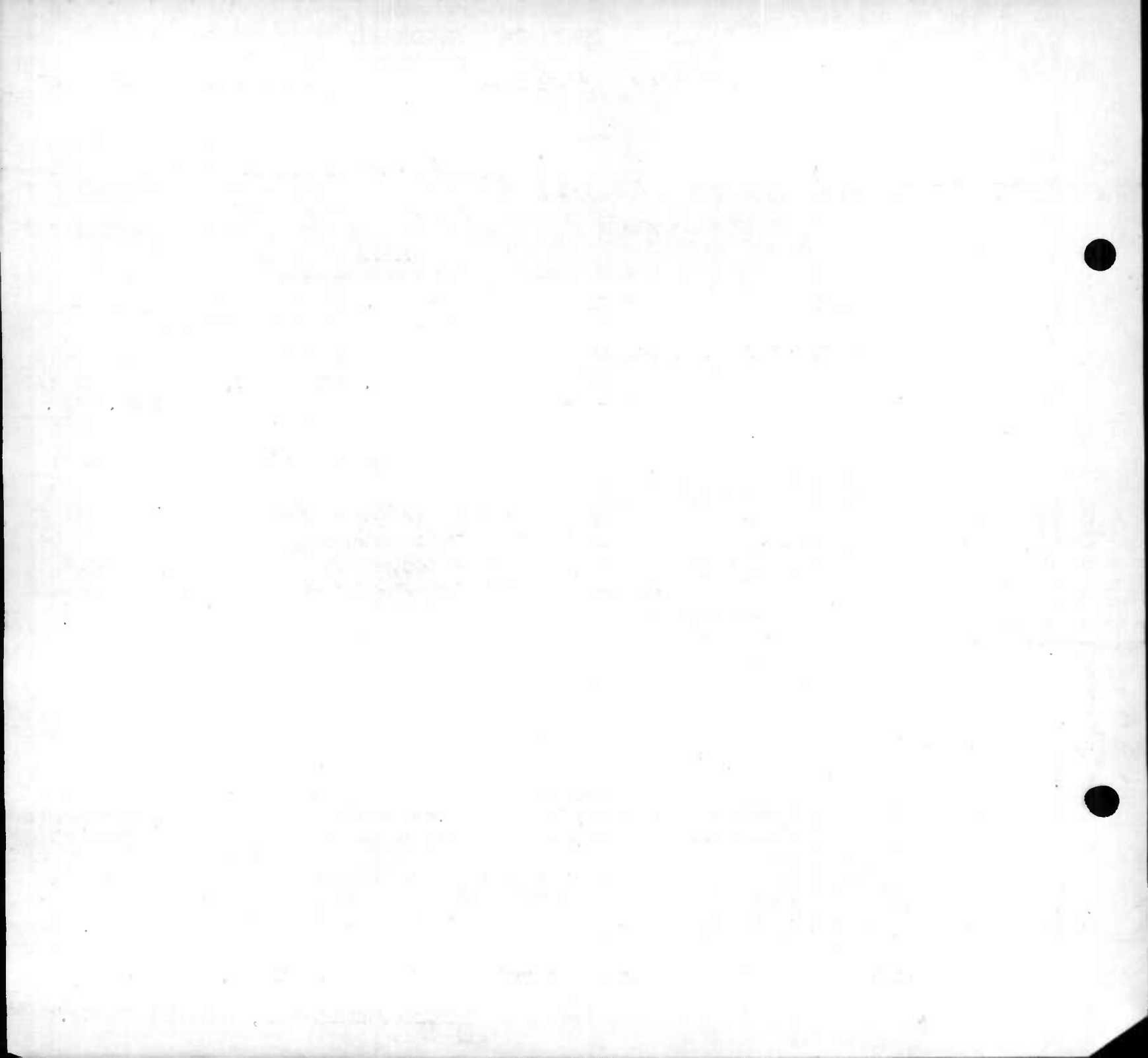
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00574	
66 00574				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		JOHN A. HAYES		JANUARY 14, 1966 1 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
4418 OLD FREDERICK ROAD 21229				MARYLAND	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
				BALTIMORE	
				D. STREET ADDRESS (If rural, give location)	
				4418 OLD FREDERICK ROAD 21229	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days
MALE	WHITE	NEVER MARRIED	5/4/1891	74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
CLERK		RETIRED		MARYLAND	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
JOHN HAYES			ELIZABETH FITZGIBBONS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		705-05-4154		MR. CHARLES V CHALMERS, 5625 OAKLAND ROAD #27	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				3 yr.	
18. ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 3-3 1959 to 1-14 1966, that (I) (me) last saw the deceased alive on 1-11 1966 and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
John F. Schaefer				1/16/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
JOHN SCHAEFER		401 RANDOM ROAD			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		1/18/66		NEW CATHEDRAL CEMETERY	
				BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 18 1966		Robert E. Taylor		HUBBARD FUNERAL HOME, 4107 WILKENS AVE. # 29	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

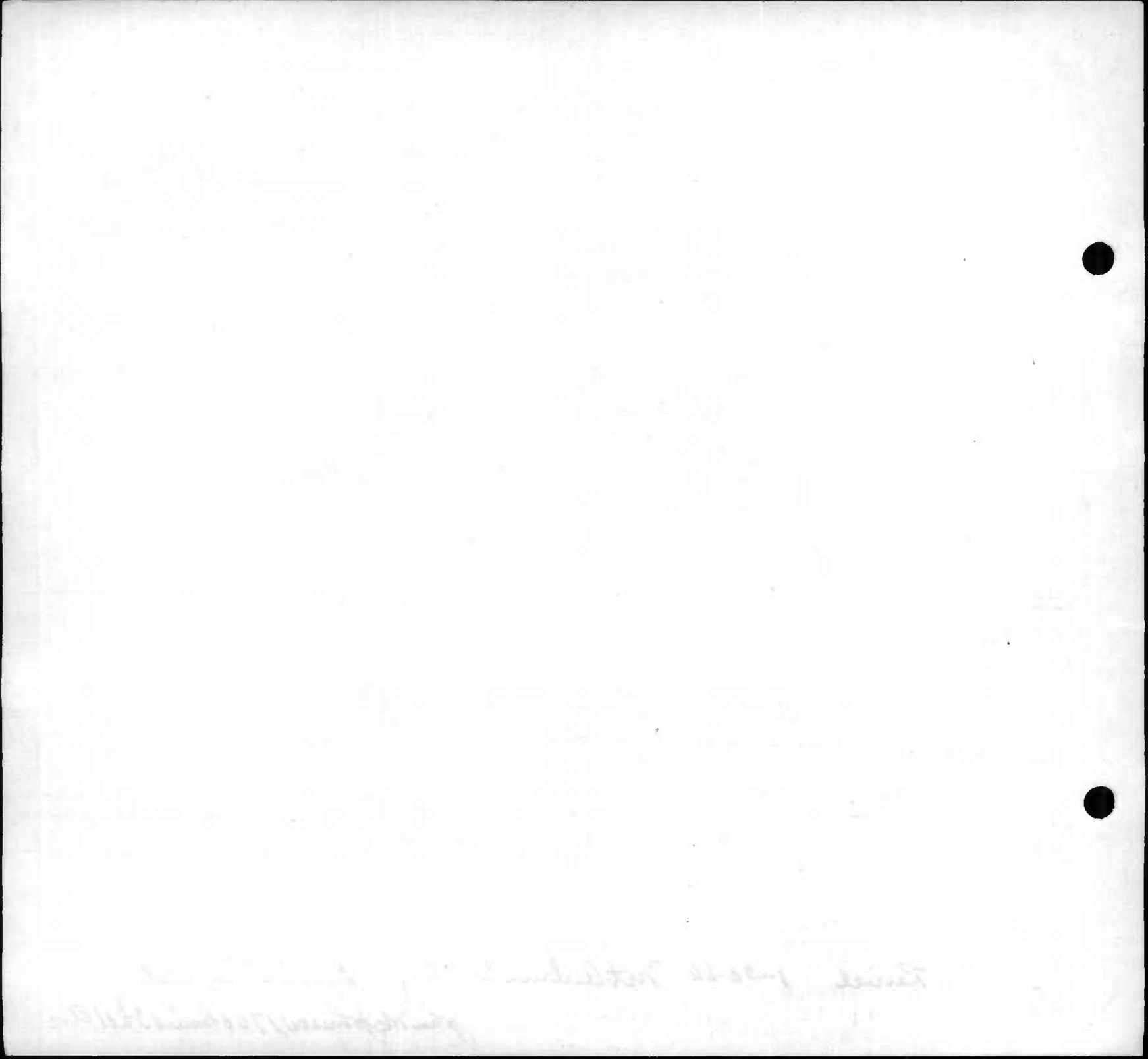
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
66 00575		CERTIFICATE OF DEATH		66 00575	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		FLORENCE MAY NELSON		1-13-66 2:35 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)		5. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MARYLAND		8. COUNTY	
36 FRANKLIN SQUARE HOSPITAL		BALTIMORE		23	
		D. STREET ADDRESS (If rural, give location)		1306 JAMES ST	
5. SEX	6. RACE	7. MARRIED-NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. AGE (In years last birthday)
F	W	WIDOWED	1882	83	83
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
FLOOR LADY		RETIRED		MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
JOSEPH BORGEALT		CARRIE NICHOLS		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		214-01-2689		MRS. DORIS BERRY, 444 CLEVELAND ROAD MEDICAL RECORDS LINTH. HGTS.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
443 X I		pulmonary edema		2 weeks	
ANTECEDENT CAUSES		(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		2 years	
		(C) DUE TO		7 years	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-12 1966 to 1-13 1966, that (I) (we) last saw the deceased alive on 1-13 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
JACINTO V. DE BORJA		1-13-66			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
JACINTO V. DE BORJA		FRANKLIN SQUARE HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		1/17/66		BALTIMORE NATIONAL CEMETERY	
				BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAR 15 1966		R. L. B. & J. B. B.		HUBBARD FUNERAL HOME, 4107 WILMENS AVE. # 29	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

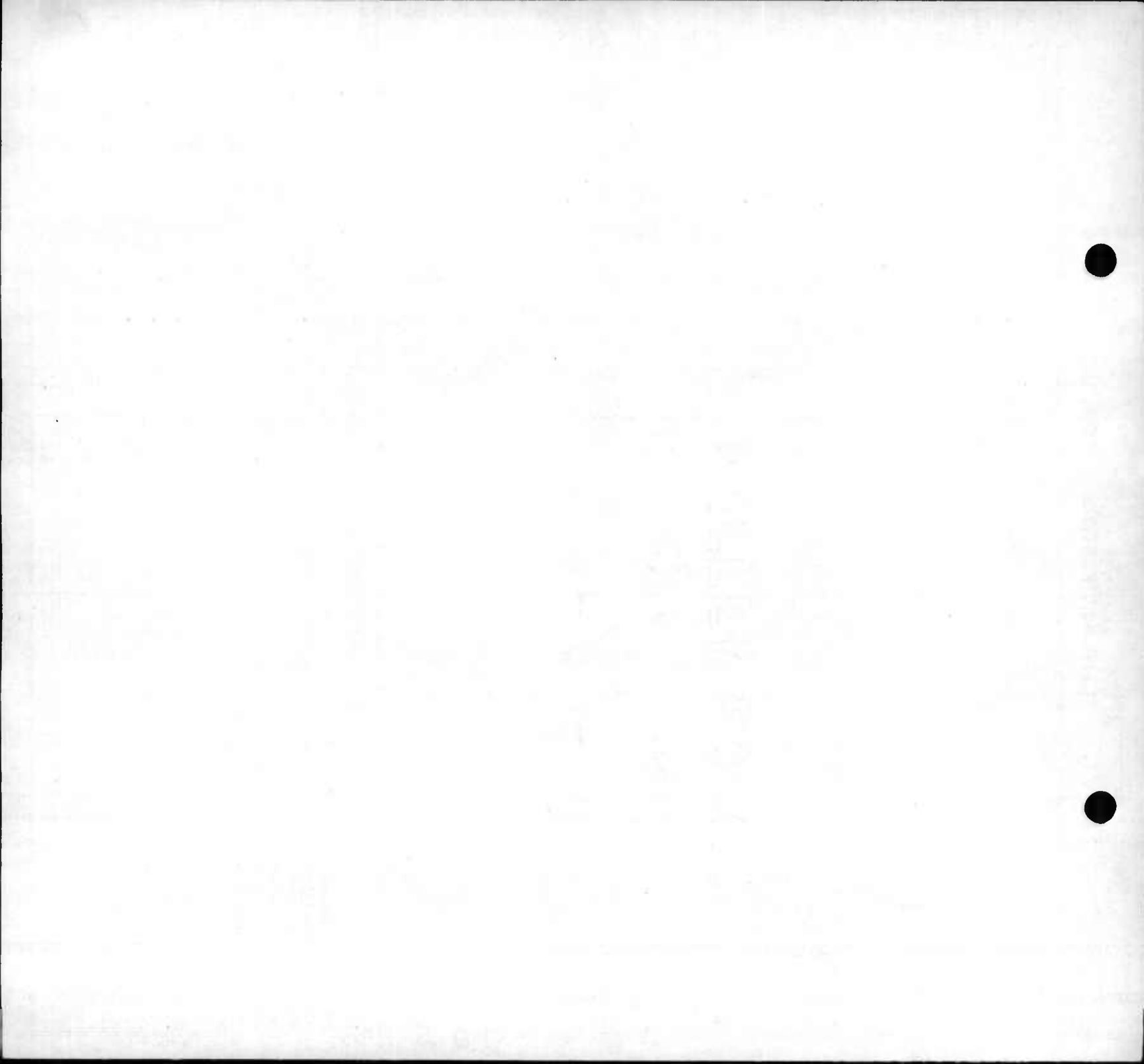
BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 66 00576					CERTIFICATE OF DEATH			Registered No. 66 00576		
1. NAME OF DECEASED (Type or Print) <i>Virginia C. Thornton</i>					2. DATE AND HOUR OF DEATH <i>Jan. 17, 1966</i> <i>9:55 A.M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>1911 N. Monroe Street</i>					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>15-04</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>1911 N. Monroe St.</i>					
5. SEX <i>Female</i>	6. RACE <i>colored</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>April 2, 1877</i>	9. AGE (In years last birthday) <i>89</i>	If Under 1 Yr. Months: Days: Hours: Min.		12. CITIZEN OF WHAT COUNTRY?			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>At home</i>		11. BIRTHPLACE (State or foreign country) <i>Pa.</i>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>Edward Page</i>					14. MOTHER'S MAIDEN NAME <i>Baroline Boothe</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <i>217-30-8779</i>		17. INFORMANT <i>Barriem Jones, daughter, 1911 N. Monroe</i>			ADDRESS		
18. <i>420.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <i>Coronary Heart Disease</i> DUE TO (B) <i>Arteriosclerotic Heart Disease</i> DUE TO (C) <i>10 yrs</i>			INTERVAL BETWEEN ONSET AND DEATH <i>one month</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Generalized Arteriosclerosis</i>										
19A. DATE OF OPERATION <i>0</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nobly medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>January 12, 1966</i> to <i>January 17, 1966</i> , that (I) (we) last saw the deceased alive on <i>Jan. 12, 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <i>Roland T. Smoot</i>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <i>1/17/66</i>		
23C. PHYSICIAN'S NAME (Type) <i>ROLAND T. SMOOT</i>					23D. ADDRESS M.D. <i>3817 Copley Rd., BALTO. 15, MD</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-20-66</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt. Auburn Cemetery</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 19 1966</i>			25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>			25C. FUNERAL DIRECTOR <i>John M. Johnson</i>			ADDRESS <i>1700 David Hill Ave</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

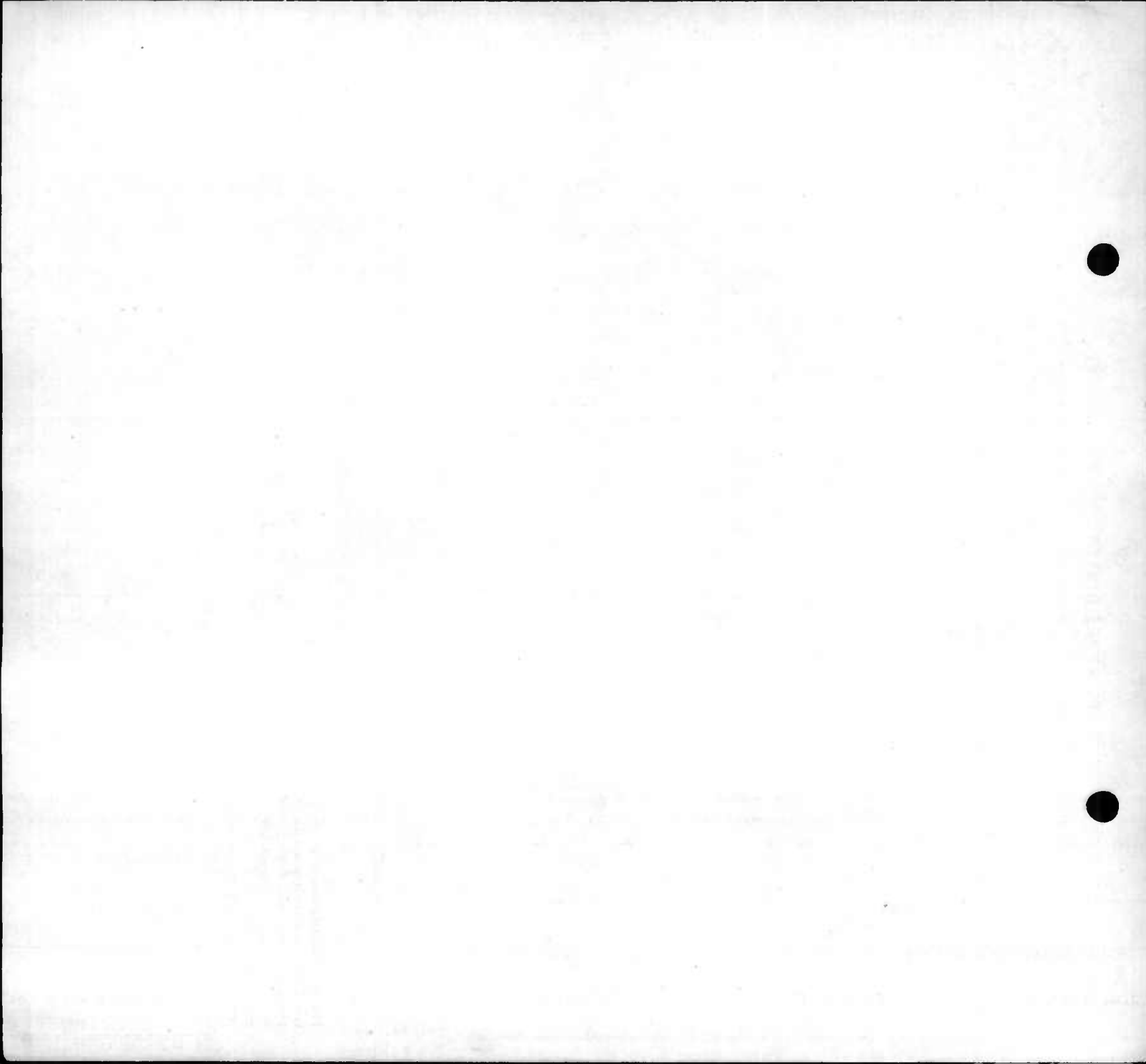
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00577	
BIRTH NO. 66 00577		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Catherine Kotchenreuther		2. DATE AND HOUR OF DEATH Jan. 16, 1966 5 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF INSTITUTE (If not in hospital or institution, give street address or location) 3815 Mt. Pleasant Ave.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3815 Mt. Pleasant Ave.			
5. SEX Fem.	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 8/15/1876	9. AGE (In years last birthday) 89	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Pallon		14. MOTHER'S MAIDEN NAME Derring		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214-54-5362		17. INFORMANT Emma Temple	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 422.11 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>myocardial infarction</i> (B) <i>chronic coronary artery disease</i> (C) <i>chronic hypertension</i>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from October 19 65 to 1/16 19 66, that (I) (we) last saw the deceased alive on 1/12 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>J. H. Goodman</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/17/66	
23C. PHYSICIAN'S NAME (Type) J. H. Goodman		23D. ADDRESS M.D. 3400 E. Baltimore St			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/18/66		24C. NAME OF CEMETERY or CREMATORY Sacred Heart Cem.	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1966		25B. NAME OF REGISTRAR R. A. E. [Signature]		25C. FUNERAL DIRECTOR Joseph N. Zannino 263 S. Conkling	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 00578	
BIRTH NO. 66 00578		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Valentine DellaPietra		2. DATE AND HOUR OF DEATH Jan. 15, 1966 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 76-08			
FULL NAME OF HOSPITAL OR INSTITUTION 3504 E. Pratt Street		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 3504 E. Pratt Street			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 1/11/1895	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) bricklayer		10B. KIND OF BUSINESS OR INDUSTRY retired		11. BIRTHPLACE (State or foreign country) Udine, Italy	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME unk		14. MOTHER'S MAIDEN NAME unk	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unk		16. SOCIAL SECURITY NO. 063-07-4860		17. INFORMANT Mr. Louis DellaPietra	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 581.1 I Cirrhosis of Liver Chronic Alcoholism		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 1-9-66 19 to 1-15-66 19, that (I) (we) last saw the deceased alive on 1-15-66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John Constantini		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1-17-66	
23C. PHYSICIAN'S NAME (Type) JOHN CONSTANTINI		23D. ADDRESS 234 S. CONKLING ST			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/18/66		24C. NAME OF CEMETERY or CREMATORY Oaklawn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1966		25B. NAME OF REGISTRAR Joseph N. Zennino		25C. FUNERAL DIRECTOR Joseph N. Zennino	
		ADDRESS 263 S. Conkling			



BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ANDREW W. MESSERSMITH

2. DATE AND HOUR PRONOUNCED DEAD

1-16-66

1:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

SINAI HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4203 Oakford Avenue 21215

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

9-23-1906

9. AGE (In years
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

OFFICE WORKER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles H. Messersmith

14. MOTHER'S MAIDEN NAME

Reiter

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes - WWII - ARMY

16. SOCIAL
SECURITY NO.

218-32-0282 - Evelyn M. Jones - 4203 Oakford

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Arteriosclerotic cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRI-
BUTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-17-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1-19-66

23C. NAME of CEMETERY or CREMATORY

New Cathedral Cemetery - Baltimore, Md

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

JAN 19 1966

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Ellsworth Armbrust
4600 Liberty/Halts

WALLLEY FORDS

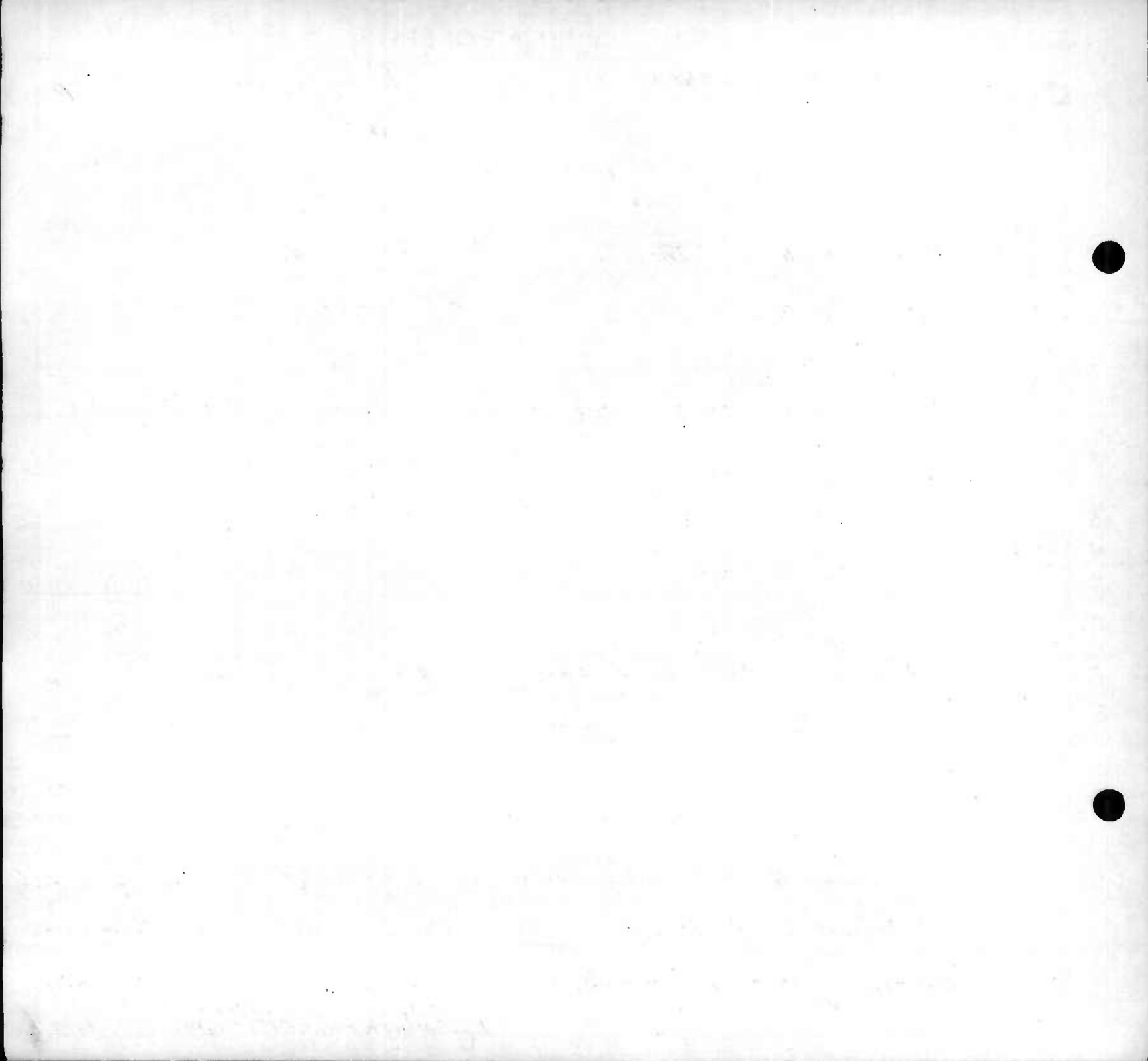
HANDOUT

WALLLEY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00580		BALTIMORE CITY HEALTH DEPARTMENT REGISTERED No. 66 00580	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) PELLAM, JAMES L.	
2. DATE AND HOUR OF DEATH January 16, 1966 5:26 P.M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital of Maryland Baltimore, Md. 21216	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2-8-41		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 7	
D. STREET ADDRESS (If rural, give location) 3615 Milford Ave		5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	
8. DATE OF BIRTH 6-5-23 9. AGE (In years last birthday) 42		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Western Electric	
11. BIRTHPLACE (State or foreign country) U. S. A. - Chicago, Ill		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward Pellam		14. MOTHER'S MAIDEN NAME Ahrons	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII - Army 162.1		16. SOCIAL SECURITY NO. 212-20-5189	
17. INFORMANT JANE C. PELLAM - 3615 Milford Ave		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Carcinomatosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Bronchogenic carcinoma		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 3/14/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA of LUNG	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NONE	
21C. WHERE DID INJURY OCCUR? NONE		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 6, 1966 to January 16, 1966, that (I) (we) last saw the deceased alive on January 16, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 5:26 PM			
23A. SIGNATURE Manuel G. Fontanilla M.D.		23B. DATE SIGNED January 16, 1966	
23C. PHYSICIAN'S NAME (Type) Manuel G. Fontanilla M.D.		23D. ADDRESS Lutheran Hospital of Md - Baltimore 16	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-20-66	
24C. NAME OF CEMETERY OR CREMATORY Meadowbranch Cemetery		24D. LOCATION (City, town, or county) (State) Westminster, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1966		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR ADDRESS ELLSWORTH ARMARIST - 4600 Liberty Heights Ave			



BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

James C. Harris

2. DATE AND HOUR PRONOUNCED DEAD

1/13/66

3:10 p.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3225 E. Fairmount Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widower

8. DATE OF BIRTH

February 18, 1909

9. AGE (In years
last birthday)

64 56

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Insurance

10B. KIND OF BUSINESS OR INDUSTRY

General Agent

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Thorndley Harris

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

No

16. SOCIAL
SECURITY NO.

212-16-9396

17. INFORMANT

Family records

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot wound of head
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

3225 E. Fairmount Ave.

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

1 13 66 ?

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

shot self in head.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/14/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Jan. 17, 1966

23C. NAME OF CEMETERY or CREMATORY

Poplar Grove Cemetery

23D. LOCATION

(City, town, or county)

(State)

Cokeysville, Balto. Co., Maryland

24A. DATE REC'D BY HEALTH DEPT.

JAN 19 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

John Burns' Sons, Towson, Maryland

ADDRESS

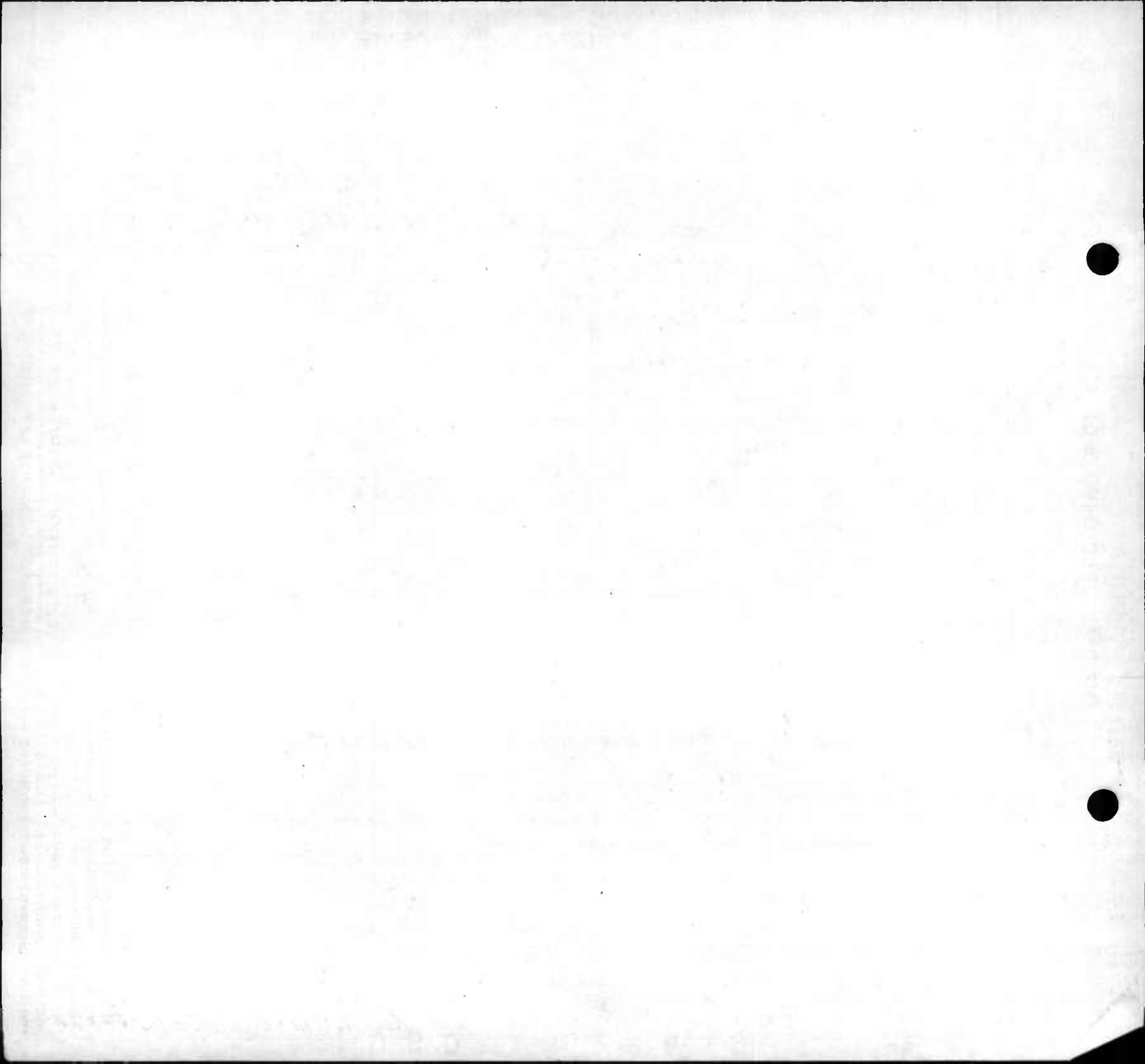
WALLER POLICE

Waller Police

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH						Registered No. 65 00582					
BIRTH NO. 66 00582		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) William A Stemmer				2. DATE AND HOUR OF DEATH 1/12/66 5:30 PM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				5. AGE (In years last birthday)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital				A. STATE Md				B. COUNTY Balto			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto Co				D. STREET ADDRESS (If rural, give location) 7821 Erie Ave			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH Jan 10, 08		9. AGE (In years last birthday) 57		10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic				10B. KIND OF BUSINESS OR INDUSTRY Commuter of Motor Vehicle				11. BIRTHPLACE (State or foreign country) Balto		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Antony Stemmer				14. MOTHER'S MAIDEN NAME Cindy Gange							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Wife		ADDRESS Same			
18. I 163 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Hemorrhage from lung. DUE TO (B) Carcinoma of lungs DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH 12 hr. 6 to 8 weeks			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from Nov 19 65 to Jan 12 19 66, that (I) (we) last saw the deceased alive on Jan 11 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Harold H. Burns MD								23B. DATE SIGNED 1-13-66			
23C. PHYSICIAN'S NAME (Type) Harold H. Burns MD				23D. ADDRESS 8106 Harford Rd. 34-Balti Md.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/15/66		24C. NAME OF CEMETERY OR CREMATORY Moreland		24D. LOCATION (City, town, or county) (State) Balto Md					
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1966		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Og Deemann		ADDRESS 6067 Hay Rd					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPT.				Registered No. 00583	
BIRTH NO. 66 00583				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Mabel K. Fisher		2. DATE AND HOUR OF DEATH Jan 15, 1966 9:18 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore (14) 27-07			
		D. STREET ADDRESS (If rural, give location) 5546 Belair Road 2914 Rosalie			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 7-8-90	9. AGE (In years last birthday) 75	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Phillip Fresh		14. MOTHER'S MAIDEN NAME Ida Clauser			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-52-3413		17. INFORMANT Mrs. E. Boyd ADDRESS 6828 Belclare Rd Baltimore, Md	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 420.01 (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Generalized arteriosclerotic heart disease		CAUSE OF DEATH (A) Generalized arteriosclerotic heart disease (B) (C) INTERVAL BETWEEN ONSET AND DEATH 10+ years			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None			
19A. DATE OF OPERATION 0 None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from Jan 15 19 66 to Jan 15 19 66 , that (H) (we) last saw the deceased alive on Jan 15 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert E. Stoner		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/15/66	
23C. PHYSICIAN'S NAME (Type) Robert E. Stoner		23D. ADDRESS Maryland General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/19/66		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1966		25B. NAME OF REGISTRAR Robert E. Stoner		25C. FUNERAL DIRECTOR ADDRESS Walter Brooks Bradley, Inc., Dundalk 21222	

1945-1946

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00584		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 00584	
1. NAME OF DECEASED (Type or Print) GORDON A. KELLER			2. DATE AND HOUR OF DEATH Jan. 15, 1966 1.35 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 27-15		
FULL NAME OF HOSPITAL OR INSTITUTION Mercy Hospital			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 2907 Thorndale Ave.,		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7/13/1901	9. AGE (In years last birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist			10B. KIND OF BUSINESS OR INDUSTRY Edw. Renneburg & Sons Co.		11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Henry V. Keller			14. MOTHER'S MAIDEN NAME Sarah Runk		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 212-07-9917		
17. INFORMANT Lolita C. Keller			ADDRESS 2907 Thorndale Ave.		
18. 331X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Intracerebral Hemorrhage			CAUSE OF DEATH (A) DUE TO spontaneous or due to vascular malformation		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH hours		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20A. DATE OF OPERATION		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-14-66 11:45 AM to 1-18-66 1:35 PM , that (I) (we) last saw the deceased alive on 1-15-66 1:35 PM , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Carmelita A. Ceballos, M.D.			23B. DATE SIGNED 1-18-66		
23C. PHYSICIAN'S NAME (Type) M.D.			23D. ADDRESS Mercy Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-18-1966		24C. NAME OF CEMETERY or CREMATORY Woodlawn	
24D. LOCATION Woodlawn		24E. CITY, TOWN, or COUNTY Md.		24F. STATE Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1966		25B. NAME OF REGISTRAR G. Howard Strong		25C. FUNERAL DIRECTOR ADDRESS 3207 W. North Ave.,	

Handwritten text, possibly a signature or name, appearing upside down.

George A. Gordon, M.D.

1-15-00

x

1-15-00

1-15-00

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 66 00585

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

BLANCHE A SILER

2. DATE AND HOUR OF DEATH

1. 15. 66 2:30 PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

Church Home Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY
Maryland BALTIMORE

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

247 S. MADEIRA ST.

5. SEX

F

6. RACE

W

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)
married

8. DATE OF BIRTH

2.15.15

9. AGE (In years)

50

If Under 1 Yr. If Under 24 Hrs.

Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Tennessee

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

ANDERSON GARLAND

14. MOTHER'S MAIDEN NAME

ANNIE DUNNAN

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

415-05-8392

17. INFORMANT

Husband (Same as above)

ADDRESS

18. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Myocardial Infarct

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

2 day

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Pneumo Throat

2 day

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES.

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

YES.

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

R. Magpan

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1.15.66

23C. PHYSICIAN'S NAME (Type)

Rodolfo I. MAGPANTAY

23D. ADDRESS

M.D. Church Home Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

Removal

24B. DATE

1/18/66

24C. NAME OF CEMETERY OR CREMATORY

Boston Cemetery

24D. LOCATION

Lot Ky.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 19 1966

25B. NAME OF REGISTRAR

R. E. J. L. H.

25C. FUNERAL DIRECTOR

Connelly Sons

ADDRESS

300 Mace Ave. (Balto. 21)

Wm. J. ...

... ..

... ..

... ..

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 00586

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

PLEASANT L. HOWARD

2. DATE AND HOUR PRONOUNCED DEAD

1-16-66

9:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1506 BOYLE STREET

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1506 Boyle Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH

August 10, 1918

9. AGE (In years
last birthday)

47

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Paint Co.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Pleasant Howard

14. MOTHER'S MAIDEN NAME

Jennie Anderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes # 2

16. SOCIAL
SECURITY NO.

215 05 9582

17. INFORMANT

ADDRESS

Mrs. Clela F. Howard 1445 Woodall St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Inactive pulmonary tuberculosis

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

1-17-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1 20 1966

23C. NAME of CEMETERY or CREMATORY

Balto. U. S. National

23D. LOCATION

(City, town, or county)

(State)

Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

JAN 19 1966

24B. NAME OF REGISTRAR

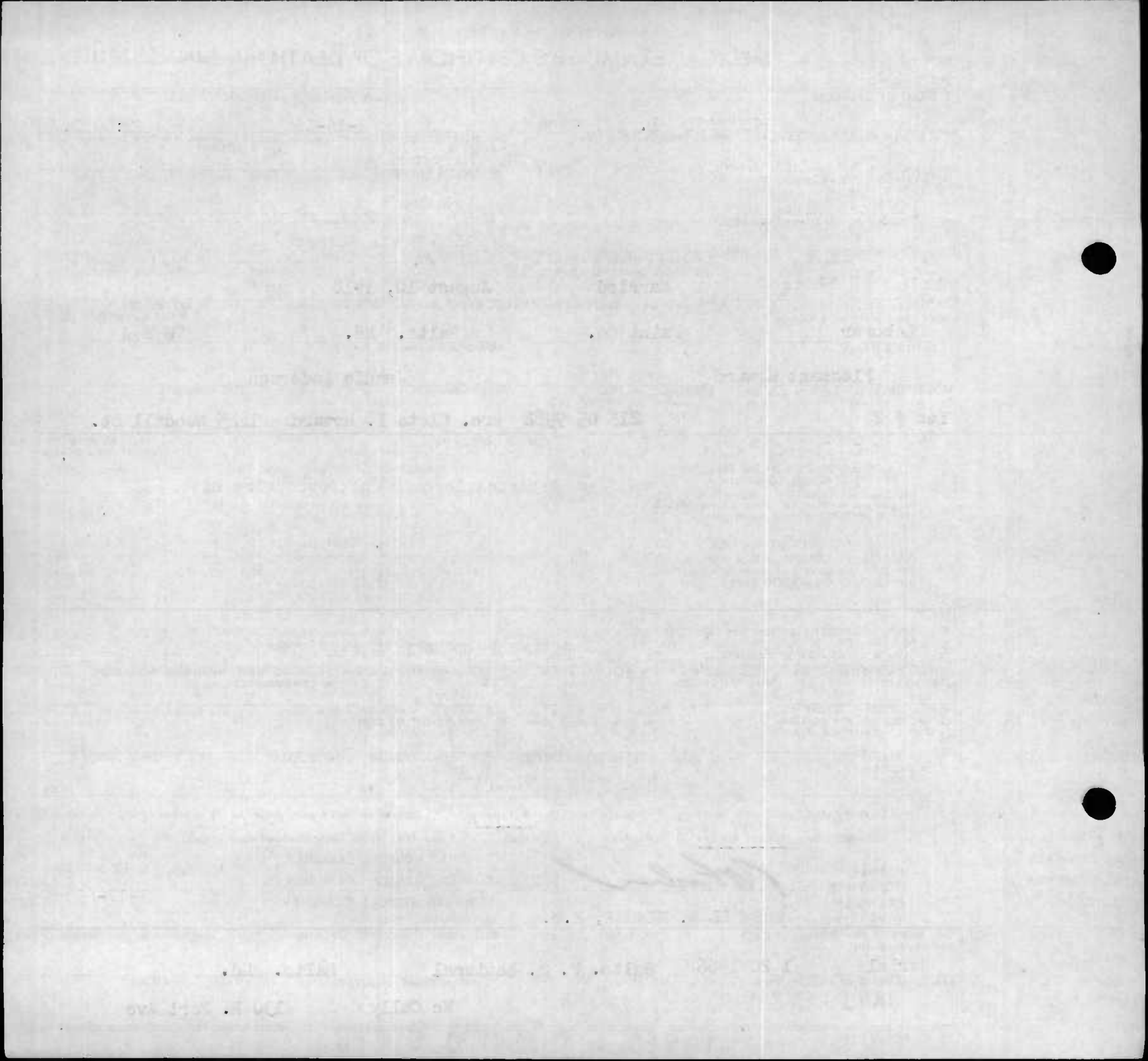
Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Mc Cully

ADDRESS

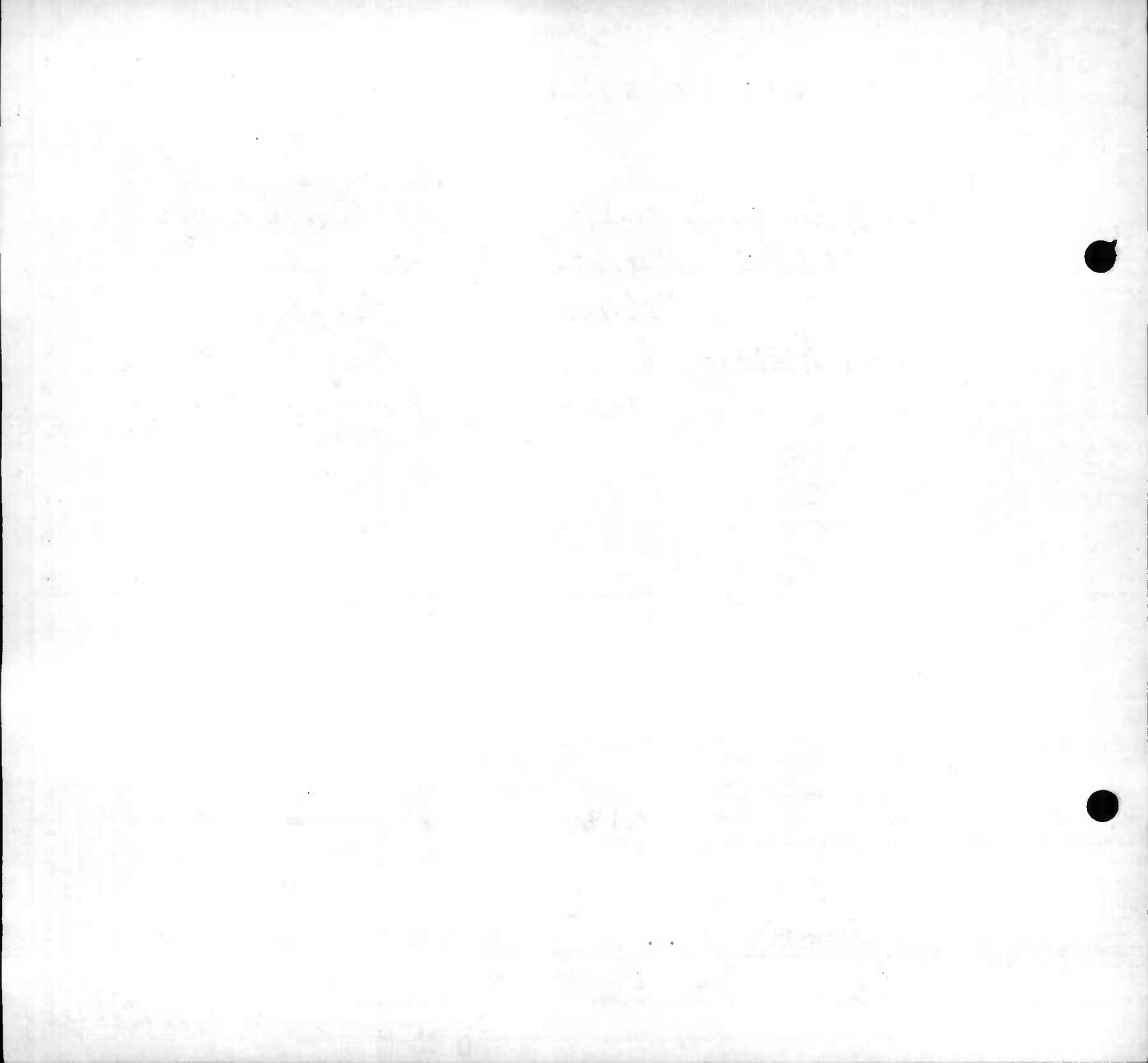
130 E. Fort Ave



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

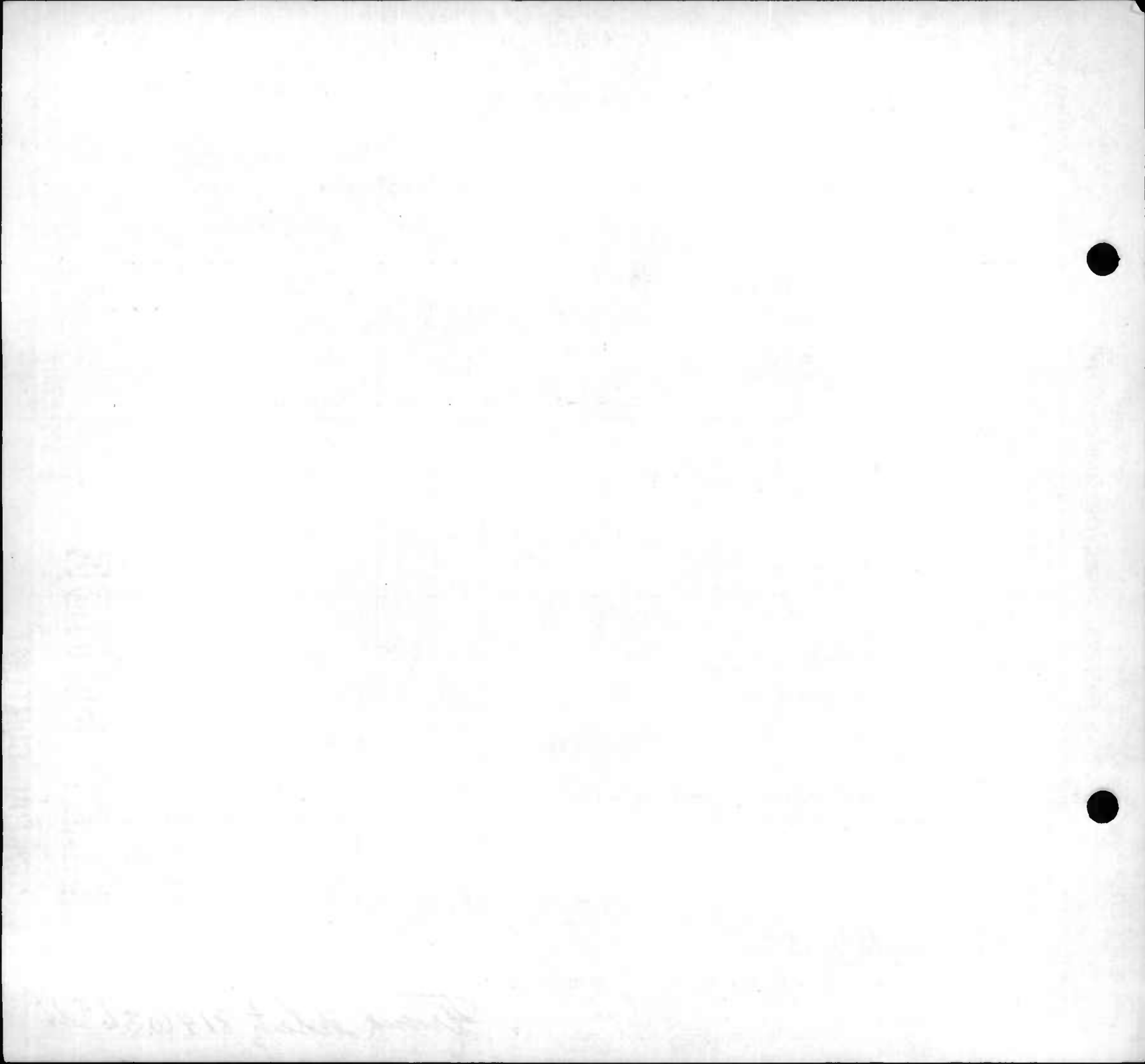
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 66 00587	
BIRTH NO. 66 00587		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) John Kleinsmith		2. DATE AND HOUR OF DEATH January 18 1966 8:55 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hosp.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #21230			
D. STREET ADDRESS (If rural, give location) 108 E. Gittings St.				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) M. White			
5. SEX M.		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 6-29-1900	
9. AGE (In years last birthday) 65		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Fred Kleinsmith	
14. MOTHER'S MAIDEN NAME May Clarty		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216 20 1071		17. INFORMANT Family - Sami	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
ANTECEDENT CAUSES				INTERVAL BETWEEN ONSET AND DEATH			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO Carcinoma of Colon			
				(B) DUE TO bleeding due to above			
				(C) metastasis (generalized)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0 -		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from January 17 1966 to 8:55 Jan 18 1966 that (we) last saw the deceased alive on 1/18/66 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Abdolhossein Samadi M.D.				23B. DATE SIGNED 1/18/66			
23C. PHYSICIAN'S NAME (Type) Abdolhossein Samadi M.D.				23D. ADDRESS South Baltimore General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) B		24B. DATE 1/18/66		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill		24D. LOCATION (City, town, or county) Baltimore (State)	
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1966		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

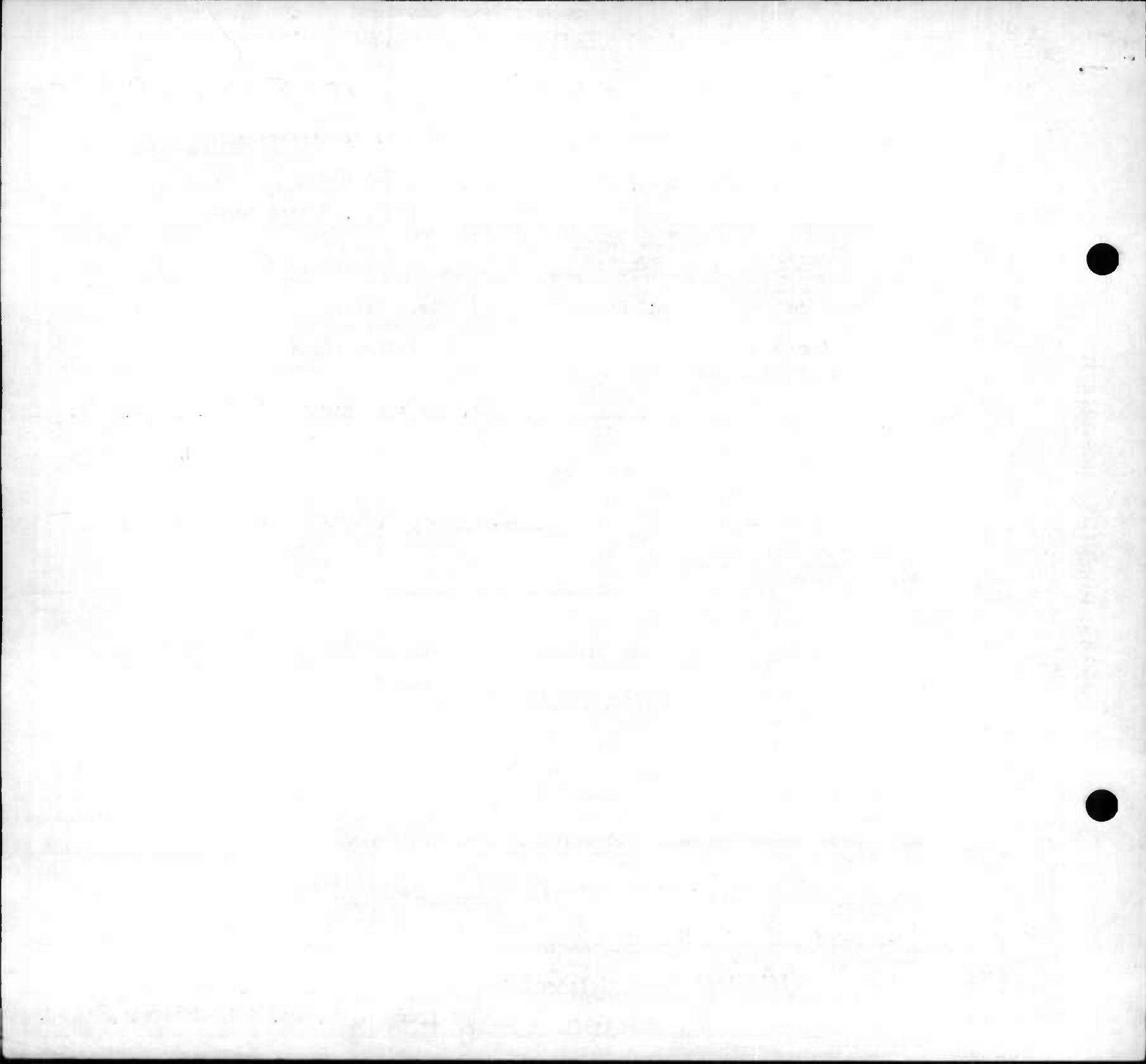
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00588	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 66 00588 CERTIFICATE OF DEATH </div>					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Nettie Ilmstadt			2. DATE AND HOUR OF DEATH Jan 15, 1966 6:37 P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Siani Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-13 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2622 W. Cold Spring Lane		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH Apr 18, 1898	9. AGE (In years last birthday) 68	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME John Newton		
14. MOTHER'S MAIDEN NAME Schaeffer			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 215-03-3109			17. INFORMANT ADDRESS Violet Bowen Route 1, Finksburg, Md.		
18. 420.1 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH Hours					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, ASCVD Years					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 20 19 63 to Jan 15 19 66 , that (H) (we) last saw the deceased alive on January 15 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Herman Brecher M.D.				23B. DATE SIGNED 1/18/66	
23C. PHYSICIAN'S NAME (Type) HERMAN BRECHER M.D.				23D. ADDRESS 443 E. 25th ST.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan 19, 1966		24C. NAME OF CEMETERY or CREMATORY Evergreen Memorial Cem	
24D. LOCATION (City, town, or county) (State) Finksburg, Md.					
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Frank J. Seitz ADDRESS 814 W 36th St	



FUNERAL DIRECTOR: IMPORTANT

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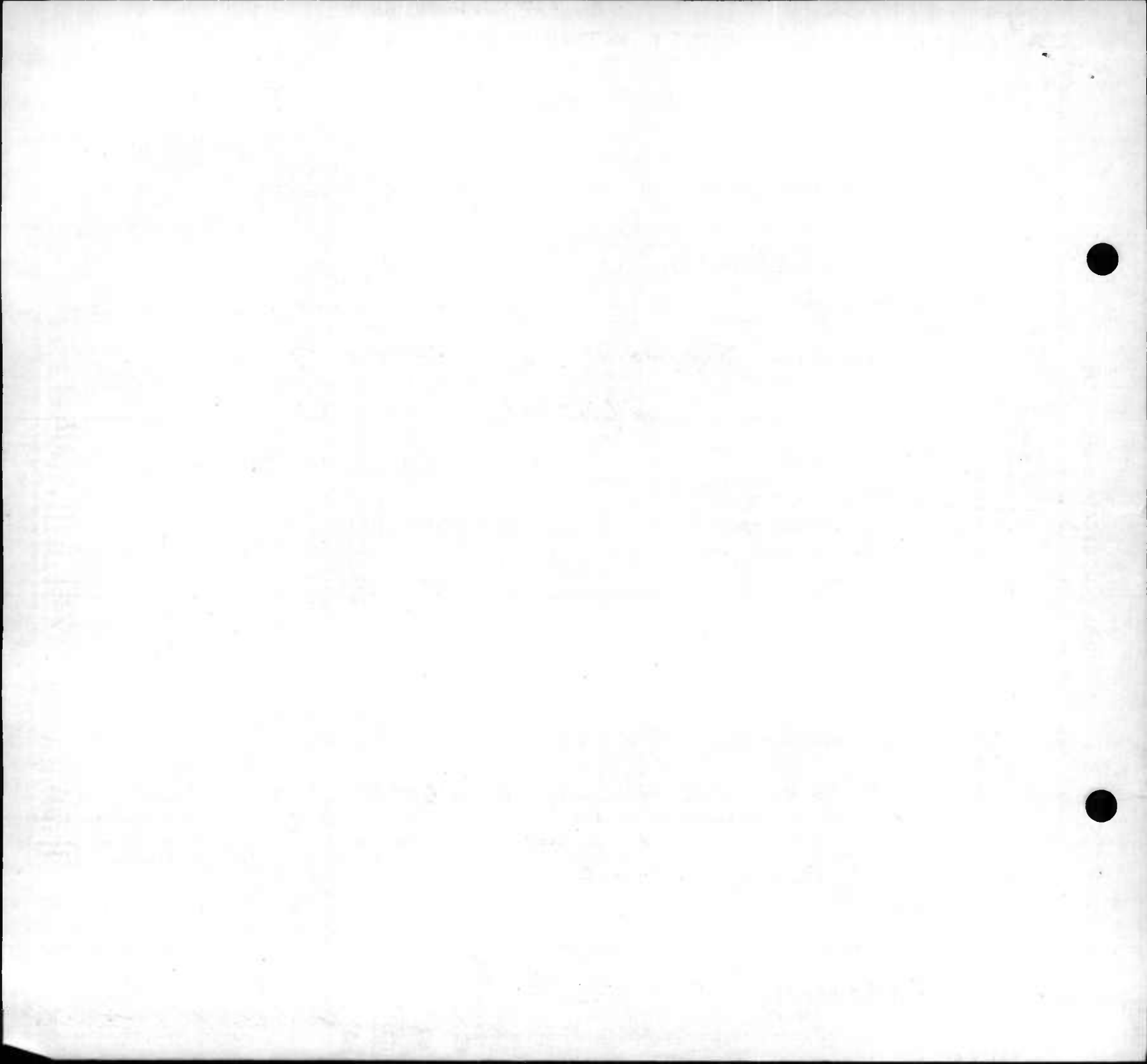
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <u>66 00589</u>				
BIRTH NO. <u>66 00589</u>					M.E. CASE NO. <u>66 00589</u>				
1. NAME OF DECEASED (Type or Print) <u>SIDNEY DUKE</u>					2. DATE AND HOUR OF DEATH <u>1-15-66 8:50 a.m.</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Sinai Hospital</u>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>2719</u> D. STREET ADDRESS (If rural, give location) <u>3706 W. Rogers Avenue</u>				
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u>	8. DATE OF BIRTH <u>60</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>		11. BIRTHPLACE (State or foreign country) <u>Rhode Island</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Leo Duke</u>					14. MOTHER'S MAIDEN NAME <u>Esther Klein</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Sanford Mervis</u>				
					ADDRESS <u>1301 N. Charles St.</u>				
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <u>Coronary Thrombosis</u> DUE TO (B) <u>Coronary Sclerosis</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2-4 hrs</u> <u>6 months</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>1/10</u> 19 <u>66</u> to <u>1/15</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/15</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Isadore K. Grossman</u> M.D.					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>1/15/66</u>		
23C. PHYSICIAN'S NAME (Type) <u>Isadore K. Grossman</u> M.D.					23D. ADDRESS <u>1527 E. North Ave</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/17/1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>Bnai Israel Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1966</u>		25B. NAME OF REGISTRAR <u>Albert S. Johnson</u>		25C. FUNERAL DIRECTOR <u>Sol Levinson & Bros.</u>		ADDRESS <u>6010 Reisterstown Rd.</u>			



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>66 00590</u>	
BIRTH NO. <u>66 00590</u>		M.E. CASE NO. <u>66 00590</u>		1. NAME OF DECEASED (Type or Print) <u>ROTHSCHILD BERTHA SONDHEIM</u>		2. DATE AND HOUR OF DEATH <u>1-15-66</u> <u>3 45 P</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>BALTIMORE MD.</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>V.S.A.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>SINAI HOSPITAL BELVEDERE AT GREEN SPRING</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
D. STREET ADDRESS (If rural, give location) <u>7239 PARK HEIGHTS AVENUE</u>							
5. SEX <u>FEMALE</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>6-26-05</u>	9. AGE (In years last birthday) <u>60</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>HOUSE WIFE</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WALTER SONDHEIM JR.</u>				14. MOTHER'S MAIDEN NAME <u>FANNIE BERNEY</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-46-2667</u>		17. INFORMANT <u>HUSBAND - MORTON</u>		ADDRESS <u>7239 PARK HEIGHTS AVE. BALTIMORE</u>	
18. <u>170X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>RESPIRATORY FAILURE</u> EXTENSIVE METASTASIS SECONDARY TO CA RT. BREAST POST OPERATIVE BIL. ADRENAL ECTOMY & PYEOROPLASTY				CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>3-16-66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CA RT METASTATIC BREAST</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>the</u> (this hospital) attended the deceased from <u>12-12-65</u> 19 <u>65</u> to <u>1-15</u> 19 <u>66</u> , that <u>we</u> last saw the deceased alive on <u>1-15</u> 19 <u>66</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>We</u> (did) <u>not</u> view the body after death.							
23A. SIGNATURE <u>Chouhath Rao</u> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>HOUSE OFFICER</u> <u>1-15-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR C. CHALABATHI RAO</u> M.D.				23D. ADDRESS <u>SINAI HOSPITAL BALTIMORE MD.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/17/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore Hebrew</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1968</u>		25B. NAME OF REGISTRAR <u>John J. Brown</u>		25C. FUNERAL DIRECTOR <u>John J. Brown</u>		ADDRESS <u>6010 Reisterstown Rd</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Certificate of Death		Registered No. 66 00591	
BIRTH NO. 66 00591							
M.E. CASE NO. 66 00591							
1. NAME OF DECEASED (Type or Print) BERNSTEIN HARRY				2. DATE AND HOUR OF DEATH 1-14-66 2¹⁰/a.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE MD.		B. COUNTY BALTIM	
SINAI HOSPITAL OF BALTIMORE, INC.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		5300	
				D. STREET ADDRESS (If rural, give location) 7601 Park Hts Ave			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7/18/87	9. AGE (In years last birthday) 78	10. Under 1 Yr. Months: Days:	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY Clothing Manuf.		11. BIRTHPLACE (State or foreign country) Baltimore, MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis Bernstein				14. MOTHER'S MAIDEN NAME Annie			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 216-09-1343		17. INFORMANT ADDRESS MRS. IDA BERNSTEIN 7601 PARK HEIGHTS AVE	
18. 704.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Pneumonia vulgaris				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO			
				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ① Steroid Rx ± 2 effects (collapsed ventricles) ② Pneumonia (Cushingoid facies, anorexia)							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Pending		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 12/5/65 to 1/14/66 , that (1) was last saw the deceased alive on 1/13/66 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (1) was (did) (did not) view the body after death.							
23A. SIGNATURE Leonard J. Hertzberg				23B. DATE SIGNED 1-14-66			
23C. PHYSICIAN'S NAME (Type) Leonard J. Hertzberg				23D. ADDRESS Sinai Hospital Baltimore, MD			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/14/66		24C. NAME OF CEMETERY or CREMATORY CHIZUK AMNO (ARLINGTON)		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1966		25B. NAME OF REGISTRAR John E. Sullivan		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD			

Handwritten notes in the top left corner, including the word "Baltimore" and other illegible cursive text.

Handwritten notes in the top right corner, including the word "Baltimore" and other illegible cursive text.

Handwritten notes in the middle left section, including the word "Baltimore" and other illegible cursive text.

Handwritten notes in the middle right section, including the word "Baltimore" and other illegible cursive text.

Handwritten notes in the bottom left section, including the word "Baltimore" and other illegible cursive text.

Handwritten notes in the bottom right section, including the word "Baltimore" and other illegible cursive text.

FUNERAL DIRECTOR: IMPORTANT

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Baltimore City Health Department				Registered No. 66 00592	
BIRTH NO. 66 00592		118 880		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Dashew, Flora Seidenman</i>		2. DATE AND HOUR OF DEATH <i>11/17/66 11:40 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE <i>md</i> B. COUNTY <i>13-01</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)	
<i>42 Sinai Hospital</i>		<i>Baltimore</i>		<i>Temple Garden Aptz Apt 1202</i>	
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>widowed</i>	8. DATE OF BIRTH <i>10/17/92</i>	9. AGE (in years last birthday) <i>73</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Executive</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>Machinery Business</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Joseph Seidenman</i>		14. MOTHER'S MAIDEN NAME <i>Bessie Seidenberg</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>219-28-1680</i>		17. INFORMANT ADDRESS <i>Mrs. Sadie Ginsberg- 3707 Chatham Road</i>	
18. <i>420.1 I</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) DUE TO <i>Myocardial infarction</i>			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO <i>ASCVD</i>			
ANTECEDENT CAUSES		(C) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>D</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <i>(D)</i> (this hospital) attended the deceased from <i>11/16</i> 19 <i>66</i> to <i>11/17</i> 19 <i>66</i> , that (I) <i>(was)</i> last saw the deceased alive on <i>11/17</i> 19 <i>66</i> and that in (my) <i>(own)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(did)</i> (did not) view the body after death.					
23A. SIGNATURE <i>Leonard J. Hertzberg</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>1-17-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Leonard J. Hertzberg</i>		M.D. 23D. ADDRESS <i>Sinai Hospital Baltimore Md</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11/19/66</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Hebrew Friendship</i>	
24D. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>		24E. (State) <i>Md</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 19 1968</i>		25B. NAME OF REGISTRAR <i>E. J. ...</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Sol Levinson & Bros Inc. 6010 Reisterstown Rd</i>	

Handwritten notes and signatures at the top of the page, including a signature that appears to be "W. B. Smith".

Handwritten signature or initials in the middle left section.

Handwritten notes and signatures at the bottom of the page, including a signature that appears to be "W. B. Smith".

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										66 00593	
CERTIFICATE OF DEATH										Registered No.	
BIRTH NO. <u>267833</u>											
M.E. CASE NO. <u>267833</u>											
1. NAME OF DECEASED (Type or Print) <u>Peregoff, Abraham</u>					2. DATE AND HOUR OF DEATH <u>4/17/66</u> <u>10⁰⁰ P.M.</u>						
3. PLACE OF DEATH IN BALTIMORE/MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Sinai Hospital</u>					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2715</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>5039 Queensberry Ave</u>						
5. SEX <u>MALE</u>		6. RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>		8. DATE OF BIRTH <u>4/10/1897</u>		9. AGE (In years last birthday) <u>68</u>		10. Under 1 Yr. Months: Days: Hours: Min. 11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-Employed</u>					10B. KIND OF BUSINESS OR INDUSTRY <u>Retail</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Peregoff</u>					14. MOTHER'S MAIDEN NAME <u>Basha</u>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>W. W. I.</u>					16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Sarah Peregoff - 5039 Queensberry Ave.</u>				
18. <u>29231</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Myeloid metaplasia</u>					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO					INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>					OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						
19A. DATE OF OPERATION <u>0</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Specify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that <u>OP</u> (this hospital) attended the deceased from <u>4/10</u> 19 <u>66</u> to <u>4/17</u> 19 <u>66</u> , that (I) <u>we</u> last saw the deceased alive on <u>4/17</u> 19 <u>66</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) (did not) view the body after death.											
23A. SIGNATURE <u>Leonard J. Hertzberg</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>										23B. DATE SIGNED <u>1-17-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Leonard J. Hertzberg</u>					23D. ADDRESS <u>Sinai Hospital Baltimore MD</u>						
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>1/19/66</u>		24C. NAME OF CEMETERY OF CREMATORY <u>Chizuk Anino Cemetery</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1966</u>					25B. NAME OF REGISTRAR <u>E. J. Hertzberg</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. 6010 Reisterstown Rd.</u>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00594		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00594	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CAROLINE ANN SCHWARTZ		2. DATE AND HOUR OF DEATH JANUARY 16, 1966 9:00P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 25-41 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1000 S. Caton Ave.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 7-20-82	9. AGE (In years last birthday) 83	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ANDREW		14. MOTHER'S MAIDEN NAME NORMA THRASHER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-01-3445		17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I CAUSE OF DEATH MYOCARDIAL INFARCTION ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE INTERVAL BETWEEN ONSET AND DEATH 48 HRS		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 1-15 19 66 to 1-16 19 66, that (X) (we) last saw the deceased alive on 1-16 19 66 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael E. Pelczar		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/16/66	
23C. PHYSICIAN'S NAME (Type) MICHAEL E. PELCZAR		23D. ADDRESS M.D. ST. AGNES HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/20/1966		24C. NAME OF CEMETERY or CREMATORY Holy Cross Cem	
24D. LOCATION (City, town, or county) (State) Ritchie Spg. Bldg. Md					
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1966		25B. NAME OF REGISTRAR R. J. Kelly		25C. FUNERAL DIRECTOR ADDRESS 1600 Hollen St	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>66 00595</u>	
BIRTH NO. <u>66 00595</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>William P. Grelek</u>		2. DATE AND HOUR OF DEATH <u>January 16, 1966</u> <u>10 9</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Kenesaw Nursing Home</u> <u>2601 Roslyn Avenue</u> <u>Baltimore, Maryland 21216</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>28-02</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>3117 Ferndale Avenue 7</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 20, 1873</u>	9. AGE (In years last birthday) <u>92</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Chemist</u>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>-</u>				14. MOTHER'S MAIDEN NAME <u>-</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>271-18-1667</u>		17. INFORMANT <u>Home Records</u>		ADDRESS	
18. <u>420.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Anterograde heart disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>6/3</u> 19 <u>65</u> to <u>1/16</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/11</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Robert A. Reiter</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>1/16/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Robert A. Reiter</u>				23D. ADDRESS M.D. <u>606 Edmondson Ave - 28</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/20/1966</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1966</u>		25B. NAME OF REGISTRAR <u>Robert A. Reiter</u>		25C. FUNERAL DIRECTOR <u>Wm J. Titzner & Sons</u>		ADDRESS <u>Baltimore, Md 117</u>	

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BIRTH NO.

66 00596

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 00596

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MILDRED N. MARSHALL

2. DATE AND HOUR PRONOUNCED DEAD

1-16-66

12:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1109 N. LONGWOOD AVENUE

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1109 N. Longwood Avenue 21216

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

July 5, 1901

9. AGE (In years
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Elliot Haywood

14. MOTHER'S MAIDEN NAME

Mary Boston

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown. (If yes, give war or dates of service))

No

16. SOCIAL
SECURITY NO.

217-05-7418

17. INFORMANT

ADDRESS

Luther Marshall JR. 1109 Longwood St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

ii

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORKNOT WHILE
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-17-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

Burial

1-21-66

Baltimore Natl. Cem.

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JAN 19 1966

R. S. Fisher

George A. Nelson 1348 N. Calhoun St.

VALLEY FOLIO

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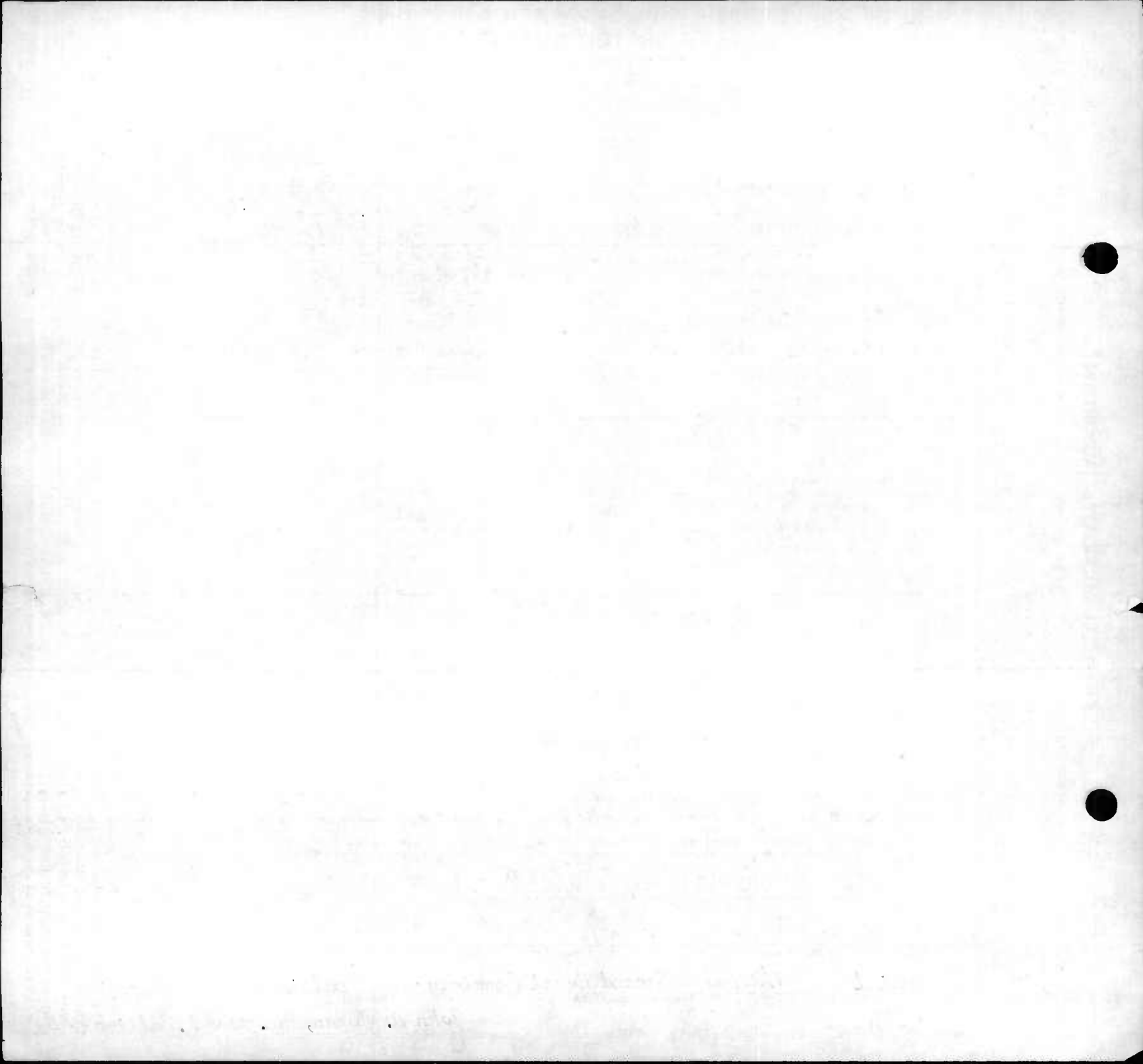
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 66 00597					CERTIFICATE OF DEATH					Registered No. 66 00597				
1. NAME OF DECEASED (Type or Print) LENA DOLLENGER					2. DATE AND HOUR OF DEATH 1/18/66 6 20 A.M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)									
FULL NAME OF (If not in hospital or institution, give street address or location) MERCY HOSP.					A. STATE MD.					B. COUNTY 26-05				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE									
					D. STREET ADDRESS (If rural, give location) 303 HORNELL ST.									
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married		8. DATE OF BIRTH 2/15/23		9. AGE (In years last birthday) 42		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) Baltimore				
12. CITIZEN OF WHAT COUNTRY?					13. FATHER'S NAME ANDREW J. HELFER					14. MOTHER'S MAIDEN NAME JOSEPHINE CORCORAN				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS				
18. 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) carcinomatosis DUE TO (B) ca of colon DUE TO (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.										INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION 0					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)				
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?					22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/27 19 65 to 1/18 19 66 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 12/27 19 66 and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.									
23A. SIGNATURE Maria Pia Caldoni										23B. DATE SIGNED 1/18/66				
23C. PHYSICIAN'S NAME (Type) MARIA PIA CALDONI										23D. ADDRESS MERCY HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 1/22/66					24C. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery				
24D. LOCATION (City, town, or county) (State) Baltimore Maryland					25A. DATE REC'D BY HEALTH DEPT. JAN 19 1966					25B. NAME OF REGISTRAR John A. Moran, Inc. 3000 E. Baltimore St				



CERTIFICATE OF DEATH

Registered No. 66 00538

BIRTH NO. N-425 66 00538

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

MARTIN K. NILSSON

2. DATE AND HOUR OF DEATH

1-17-66 8:11 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

512 North Rose Street 21205

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED

Never Married

8. DATE OF BIRTH

2-11-1888

9. AGE (In years
last birthday)

77

If Under 1 Yr.

Months: Days: Hours: Min.

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel

11. BIRTHPLACE (State or foreign country)

Sweden

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Martin Nilsson

14. MOTHER'S MAIDEN NAME

Carlina

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

216-10-4717

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue 21224

18.

420.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) DUE TO

Myocardial infarction

6 hours

(B) DUE TO

Arteriosclerosis

Many years

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Cirrhosis

Many years

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-14 1966 to 1-17 1966,
that (I) (we) last saw the deceased alive on 1-17 1966 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Thomas Zizic

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

1-18-66

23C. PHYSICIAN'S
NAME (Type)

Thomas Zizic

23D. ADDRESS

M.D. 4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1-20-1966

24C. NAME OF CEMETERY or CREMATORY

Sacred Heart

24D. LOCATION

(City, town, or county)

(State)

Baltimore County, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JAN 19 1966

25B. NAME OF REGISTRAR

R. L. Zizic

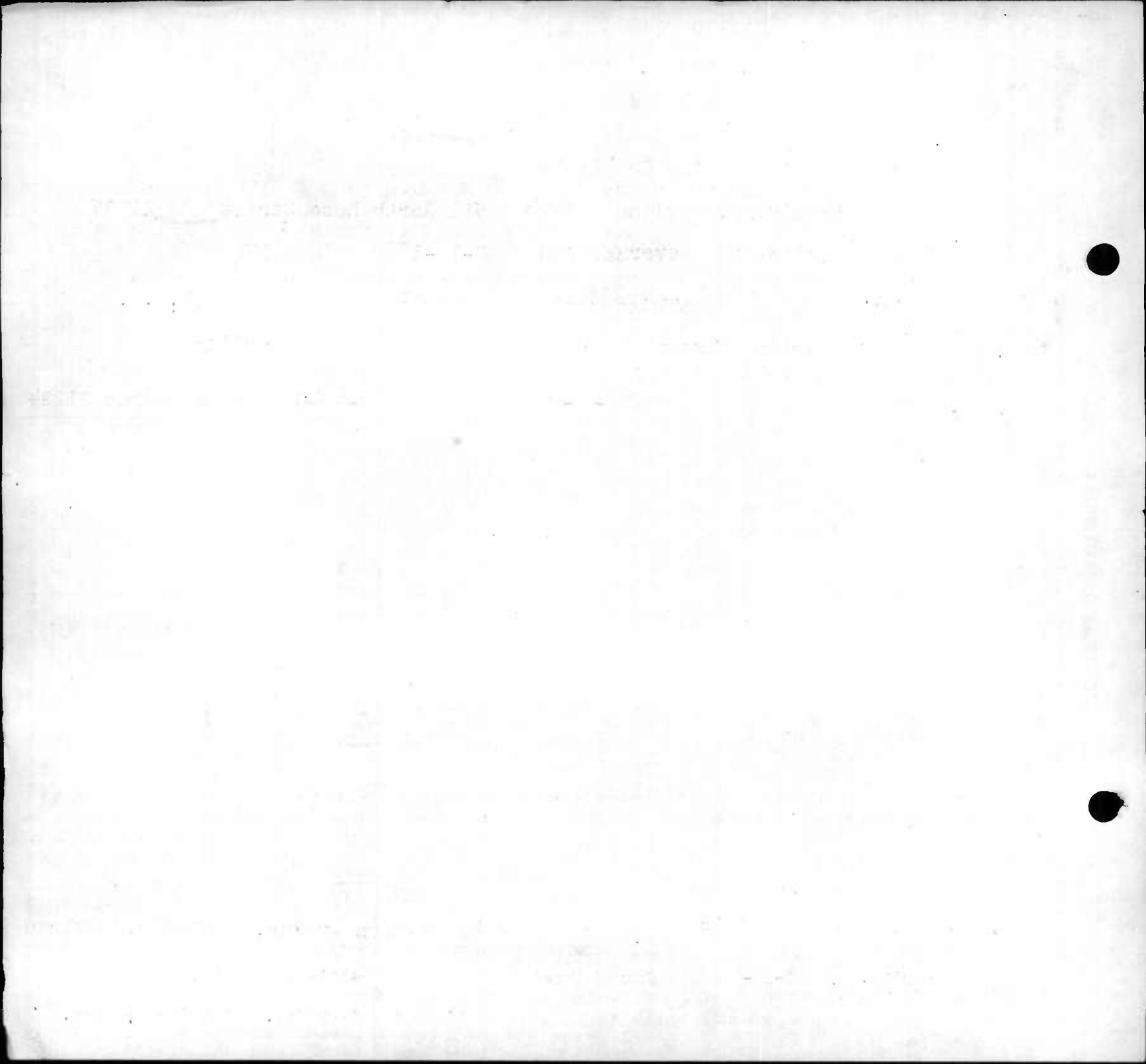
25C. FUNERAL DIRECTOR

Lilly & Zeiler Inc. 1901 Eastern Ave.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



BIRTH NO.

66 00539

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

66 00539

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Calvin Wallace

2. DATE AND HOUR PRONOUNCED DEAD

1/14/66 8:17 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

335 Presstman St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Aug 26, 1938

9. AGE (In years
last birthday)

27

10. Under 1 Yr. 11 Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Delivery Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Grocery Store

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Reuben Wallace

14. MOTHER'S MAIDEN NAME

Eva V. Davenport

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Claudette Britt 2921 Rockrose Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Pleural empyema, right
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

partial

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/14/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1/18/66

23C. NAME of CEMETERY or CREMATORY

Mount Auburn Cem

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JAN 19 1966

24B. NAME OF REGISTRAR

Robert E. Spitz, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Herbert E. Nutter 3035 W. North Ave


73

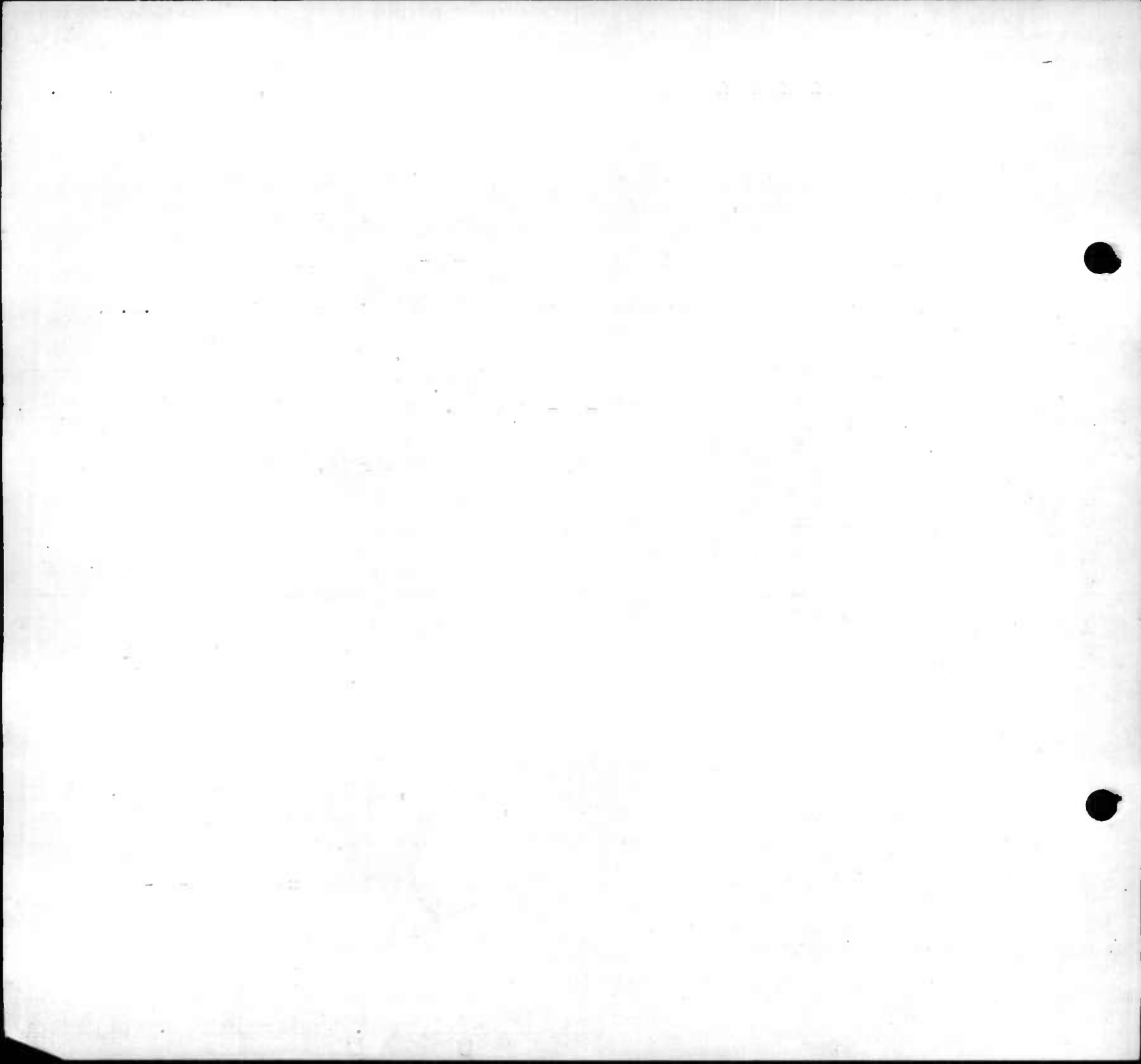
VALLEY COLLEGE

[Faint signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 00600</u>	
BIRTH NO. <u>66 00600</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Lillian Tisdale</u>		2. DATE AND HOUR OF DEATH <u>January 15, 1966</u> <u>10:25 P.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1302</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland</u>		D. STREET ADDRESS (If rural, give location) <u>2103 Callow Avenue</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u>	8. DATE OF BIRTH <u>4-13-33</u>	9. AGE (In years last birthday) <u>33</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Private Family</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia (Nottaway)</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Waverly Tisdale</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Lee</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-32-1871</u>		17. INFORMANT <u>Mrs. Lillian Dawson</u> <u>Mr. Roosevelt Tisdale</u>	
18. <u>171X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>ANTECEDENT CAUSES</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <u>Carcinoma of cervix, terminal</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>January 15, 1966</u> to <u>January 15, 1966</u> , that (I) (we) last saw the deceased alive on <u>January 15, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1-16-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Andre Rigaud</u>		23D. ADDRESS M.D. <u>1514 Division Street</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/19/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Mount Auburn Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1966</u>			
25B. NAME OF REGISTRAR <u>Herbert E. Nutter</u>		25C. FUNERAL DIRECTOR ADDRESS <u>3035 W. North Ave</u>			



66 00601

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 00601

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LILLIAN M. YOUNG

2. DATE AND HOUR PRONOUNCED DEAD

1-16-66

2:00 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2403 W. LANVALE STREET

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2403 W. Lanvale Street 21216

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

8-24-1877

9. AGE (In years
last birthday)

88

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

School Teacher

10B. KIND OF BUSINESS OR INDUSTRY

Baltimore City

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Alfred Young

14. MOTHER'S MAIDEN NAME

Emma T. Carpenter

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Robert J. Young - 2401 W. Lafayette Ave.

18. 422.1 + E916.0
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A) Arteriosclerotic cardiovascular disease
DUE TO

(B) DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Burns of trunk and extremities

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

In kitchen at
2403 W. Lanvale Street21D. TIME
OF INJURY
(APPROX.)

(Month)

1

(Day)

16

(Year)

'66

(Time)

AM

21E. INJURY OCCURRED

WHILE AT
WORK☐NOT WHILE
AT WORK☒

21F. HOW DID INJURY OCCUR?

Presumably clothing
caught fire from gas burner on stove

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)Russell S. Fisher
M.D.
RUSSELL S. FISHER, M.D.CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-17-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1-19-66

23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JAN 19 1966

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

ADDRESS

Charles R. Law 802 Madison Ave.

WALLEY & GORGE

WALLEY & GORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00602	
66 00602				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		MAMIE Mc CARTNEY		1-15-66 3:25 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION FRANKLIN SQUARE HOSPITAL			A. STATE MARYLAND B. COUNTY BALTIMORE 28		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			D. STREET ADDRESS (If rural, give location)		
			227 N. FULTON AVE		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
F	C	WIDOWED	Oct 1, 1895	70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE				GEORGIA	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
LUKE DAVIS			ANNA SAMPSON		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		?		RUGUSTA GOSS 1837 N. Wolf Balt. 13, Md. (SISTER)	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) CVA, Hemorrhage DUE TO (B) Hypertension et al? DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 2-3 days? 2-3 yrs.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
O					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-14 1966 to 1-15 1966, that (I) (we) last saw the deceased alive on 1-15 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jacinto V. de Borja M.D.				23B. DATE SIGNED 1-15-66	
23C. PHYSICIAN'S NAME (Type) JACINTO V. DE BORJA M.D.				23D. ADDRESS FRANKLIN SQUARE Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		1-20-66		Mt. Calvary	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)			
Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 19 1966		Robert E. ...		Charles R. Law, 802 Madison Ave.	

10 1000

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

William Barney

2. DATE AND HOUR PRONOUNCED DEAD

1/11/66 9:15 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

727 S. Hanover St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

87

10. Under 1 Yr. (If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

JOHN H. BARNEY

14. MOTHER'S MAIDEN NAME

LAURA

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

BERNARD F. BARNEY 727 S. HANOVER ST.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, lnm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/11/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

1-14-66

23C. NAME OF CEMETERY or CREMATORY

MOUNT. AUBURN

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JAN 19 1966

P. J. 8. J. J. J. J.

I. L. BROWN & SON 123 W. MONTGOMERY ST.

RECEIVED

NOV 19 1964

U.S. DEPT. OF JUSTICE

THE OFFICE OF THE ATTORNEY GENERAL

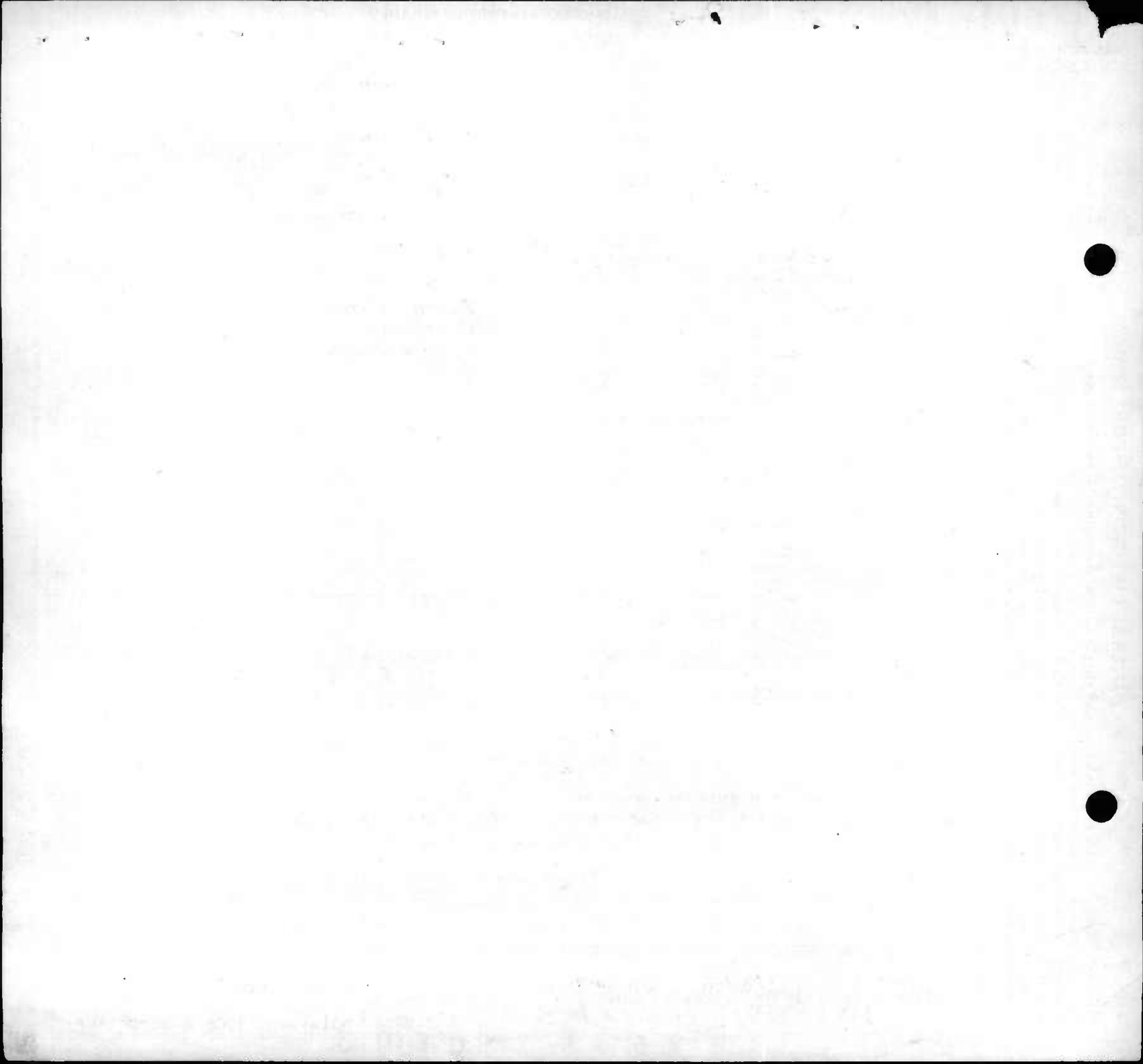
Wm. V. Galt

U.S. DEPT. OF JUSTICE

THE OFFICE OF THE ATTORNEY GENERAL

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 00604	
BIRTH NO.		M.E. CASE NO. 66 00604		2. DATE AND HOUR OF DEATH		JANUARY 14 1966 9:30 P.M.	
1. NAME OF DECEASED (Type or Print) FRANK TISDALE				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				A. STATE MARYLAND		B. COUNTY 16-01	
FULL NAME OF HOSPITAL OR INSTITUTION University Hospital				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		D. STREET ADDRESS (If rural, give location) 1105 LAURENS ST	
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 9-6-29	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUSTODIAN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. 493X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) pneumonia				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 2 wks	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. glomerulonephritis & renal failure hepatic failure				(B) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. alcoholism							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from January 11 1966 to January 14 1966, that (X) (we) last saw the deceased alive on January 14 1966 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Susan L. Howard, M.D.				23B. DATE SIGNED 15 Jan 66			
23C. PHYSICIAN'S NAME (Type) Susan L. Howard, M.D.				23D. ADDRESS University Hosp. Balt. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/20/66		24C. NAME OF CEMETERY or CREMATORY Kings Tree		24D. LOCATION (City, town, or county) (State) South Carolina	
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1966		25B. NAME OF REGISTRAR Robert E. Galt, M.D.		25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W North Ave	



BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 66 00605

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GRACE COPLAND DAVIS

2. DATE AND HOUR PRONOUNCED DEAD

January 15, 1966 11:05 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY 16-06

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3016 Arunah Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Separated

8. DATE OF BIRTH

6/24/29

9. AGE (In years last birthday)

42

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Richmond Va

12. CITIZEN OF WHAT COUNTRY?

U S A

13. FATHER'S NAME

Ike Davis

14. MOTHER'S MAIDEN NAME

Annie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Annie Allen 3016 Arunah Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED
1/16/66

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

1/20/66

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cemetery

23D. LOCATION

(City, town, or county)

(State)

A A County Md

24A. DATE REC'D BY HEALTH DEPT.

JAN 19 1966

24B. NAME OF REGISTRAR

Robert E. Petty, M.D.

24C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W North Ave

ADDRESS

WALLLEY PHONE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 00606

BIRTH NO. 66 00606

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Pearline Shaw

2. DATE AND HOUR PRONOUNCED DEAD

1/17/66 3:40 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 1708 Druid Hill Ave.

D. STREET ADDRESS (If rural, give location)

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

6/

9. AGE (In years
last birthday)

28

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laundry

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

James Shaw

14. MOTHER'S MAIDEN NAME

Myrtle

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

219-26-4525

17. INFORMANT

ADDRESS

Mrs Myrtle Shaw 1404 Madison Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Bronchopneumonia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Fatty liver

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/18/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1/20/66

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cemetery

23D. LOCATION

(City, town, or county)

Baltimore Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

JAN 19 1966

24B. NAME OF REGISTRAR

Robert E. Spitz

24C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W North Ave

ADDRESS

VALLEY POLICE

Warrant - Pick

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>66 00607</u>	
BIRTH NO. <u>66 00607</u>				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <u>Leola C. Parker</u>				2. DATE AND HOUR OF DEATH <u>Jan. 18/66</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>412 Westgate Rd</u>				A. STATE <u>Md</u> B. COUNTY <u>28-04</u>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>City</u>			
				D. STREET ADDRESS (If rural, give location) <u>412 Westgate Rd</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>Dec 17/1900</u>	9. AGE (In years last birthday) <u>65</u>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>John Harris</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Combs</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>218-03-5688</u>		17. INFORMANT ADDRESS <u>John M. Parker 83 Braeside</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>420.1 I</u>				CAUSE OF DEATH (A) <u>ACUTE CORONARY OCCLUSION</u> 6 hrs			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>AURICULAR FIBRILLATION</u> 1 wk			
				(C) <u>HYPERTENSIVE C-V. DISEASE</u> 1 yr.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1/17/66</u> 19 <u>66</u> to <u>1/18/66</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/17/66</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Norman R. Kleiman</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>1/19/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>NORMAN R KLEIMAN</u>				23D. ADDRESS <u>3803 EDMONDSON AVE</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>Jan 21/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Bldg.</u>		24D. LOCATION (City, town, or county) (State) <u>Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1966</u>		25B. NAME OF REGISTRAR <u>Paul E. Tubana</u>		25C. FUNERAL DIRECTOR ADDRESS <u>W. H. 870. 4101 Edmondson</u>			

FUNERAL DIRECTOR: IMPORTANT

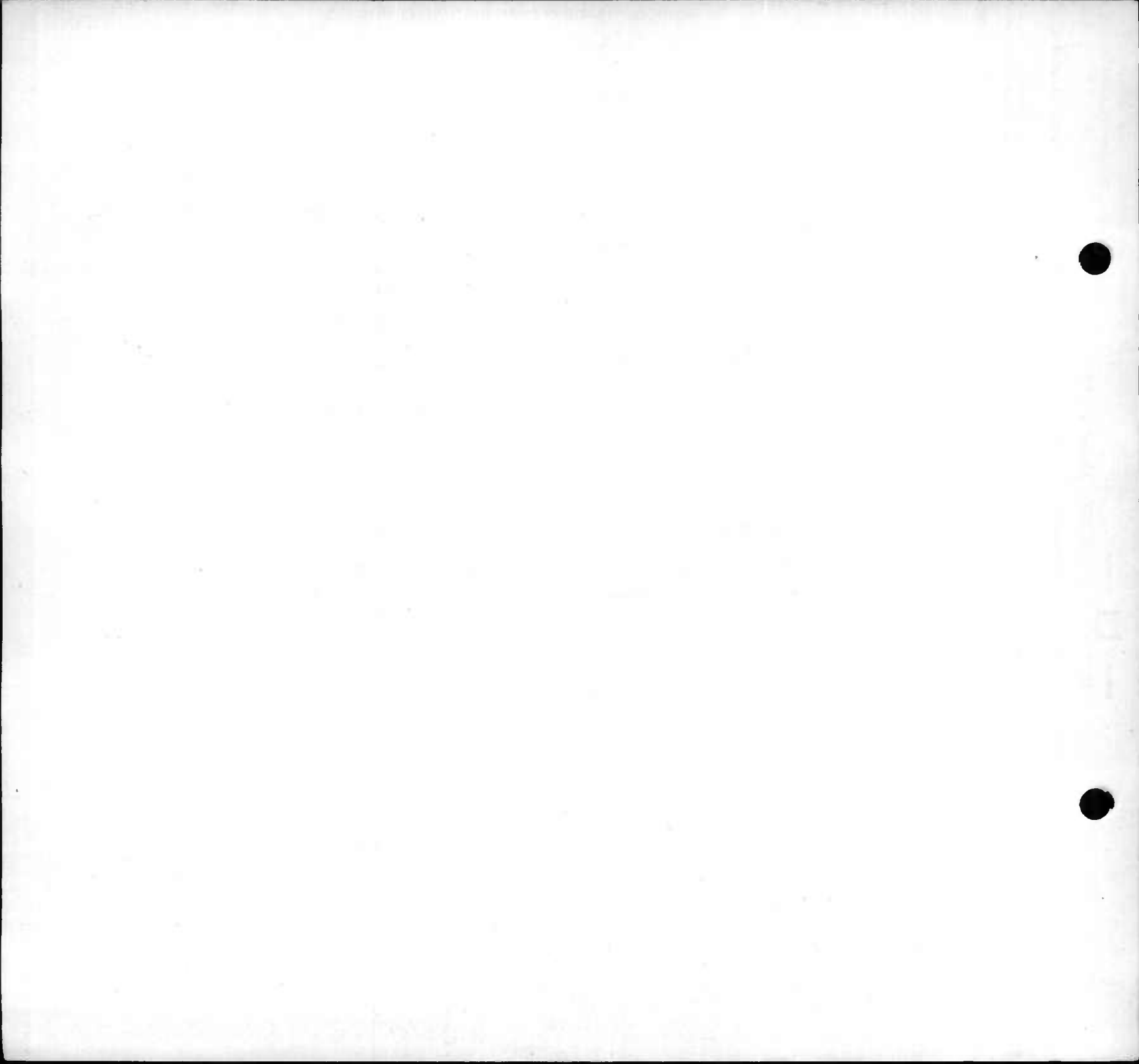
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00608		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00608	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Gilson, Margaret</u>		2. DATE AND HOUR OF DEATH <u>Jan. 17, 1966</u> <u>13.25</u> a. m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>12-06</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bolton Hill Nursing Community Cen.</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>2622 N. Charles St</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Div.</u>	8. DATE OF BIRTH <u>11/9/81</u>	9. AGE (In years last birthday) <u>84</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Actress</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Nursing Home Records</u>	
18. <u>450.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Arteriosclerosis</u> DUE TO (B) <u>Diverticulosis</u> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>Several years.</u> <u>Several years.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1949</u> to <u>January</u> , <u>1966</u> , that (I) (we) last saw the deceased alive on <u>January 16</u> , <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>E. Ellsworth Cook</u>				23B. DATE SIGNED <u>1-17-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>E. Ellsworth Cook, Jr.</u>		23D. ADDRESS <u>2418 31 Maryland Avenue, Baltimore 18, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Buried</u>		24B. DATE <u>Jan. 18/66</u>		24C. NAME of CEMETERY or CREMATORY <u>New Cathedral Boro</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1966</u>		25B. NAME OF REGISTRAR <u>R. G. E. Johnson</u>		25C. FUNERAL DIRECTOR <u>Witherby H. H. O. Edmondson</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00609		BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED NO. 66 00609	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Bertha Anna Schroeter</i>		2. DATE AND HOUR OF DEATH <i>Jan 17/66</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>German Home</i>		A. STATE <i>md</i> B. COUNTY <i>2804</i>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)			
<i>22 S. Arch St</i>		<i>22 S. Arch Ave</i>			
5. SEX <i>Female</i>	6. RACE <i>W.</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Singl</i>	8. DATE OF BIRTH <i>May 7/19</i>	9. AGE (In years last birthday) <i>86</i>	10. If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Germany</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Paul E. Schroeter</i>		14. MOTHER'S MAIDEN NAME <i>Anna Schroeter</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>315-01-2456A</i>		17. INFORMANT <i>Records German Home</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <i>Bronchopneumonia</i>		CAUSE OF DEATH (A) DUE TO <i>Acute Cardiac failure</i>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Arteriosclerotic myocardial degeneration & failure</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Oct 1965</i> to <i>17 Jan 1966</i> , that (I) (we) last saw the deceased alive on <i>17 Jan 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>William J. Bryson</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>17 Jan 65</i>	
23C. PHYSICIAN'S NAME (Type) <i>William J. Bryson</i>		23D. ADDRESS <i>4605 Edmondson Ave Balto md</i>			
24A. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Jan 19/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Louison St</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto. Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 19 1966</i>		25B. NAME OF REGISTRAR <i>Paul E. Taylor</i>	
25C. FUNERAL DIRECTOR <i>4605 Edmondson</i>		ADDRESS <i>Ave</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>2</u> <u>66 00610</u>				CITY OF BALTIMORE		REGISTERED NO. <u>66 00610</u>	
M.E. CASE NO. <u>66 00610</u>				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>SELLMAN CHARLOTTE MAY</u>				2. DATE AND HOUR OF DEATH <u>JAN 17/66 1.15 p.m.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY OF MARYLAND HOSPITAL</u>				A. STATE <u>Md.</u> B. COUNTY <u>22</u>			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>DUNDALK, BALTIMORE</u>			
D. STREET ADDRESS (If rural, give location) <u>216 Pinewood Road 5300</u>							
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>5-20-20</u>	9. AGE (In years last birthday) <u>45</u>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>WILLIAM SCRIVEN</u>				14. MOTHER'S MAIDEN NAME <u>MARY GELDMACHER</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Wm. F. Sellman Jr 216 Pinewood Rd</u>		
18. <u>414X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac Arrest</u>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <u>Rheumatic heart with</u> <u>valvular disease</u>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>1/14/66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>HEART DISEASE</u>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1/11/66</u> 19 to <u>1/17</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/17</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>B.N. Irani</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>Jan 17 '66</u>	
23C. PHYSICIAN'S NAME (Type) <u>B.N. Irani</u>				23D. ADDRESS <u>Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Jan 21/66</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Meadowdale</u>		24D. LOCATION (City, town, or county) (State) <u>Md. Howard Co</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>Wm. F. Sellman Jr</u>		ADDRESS <u>401 Edmondson</u>	

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FUNERAL DIRECTOR: IMPORTANT

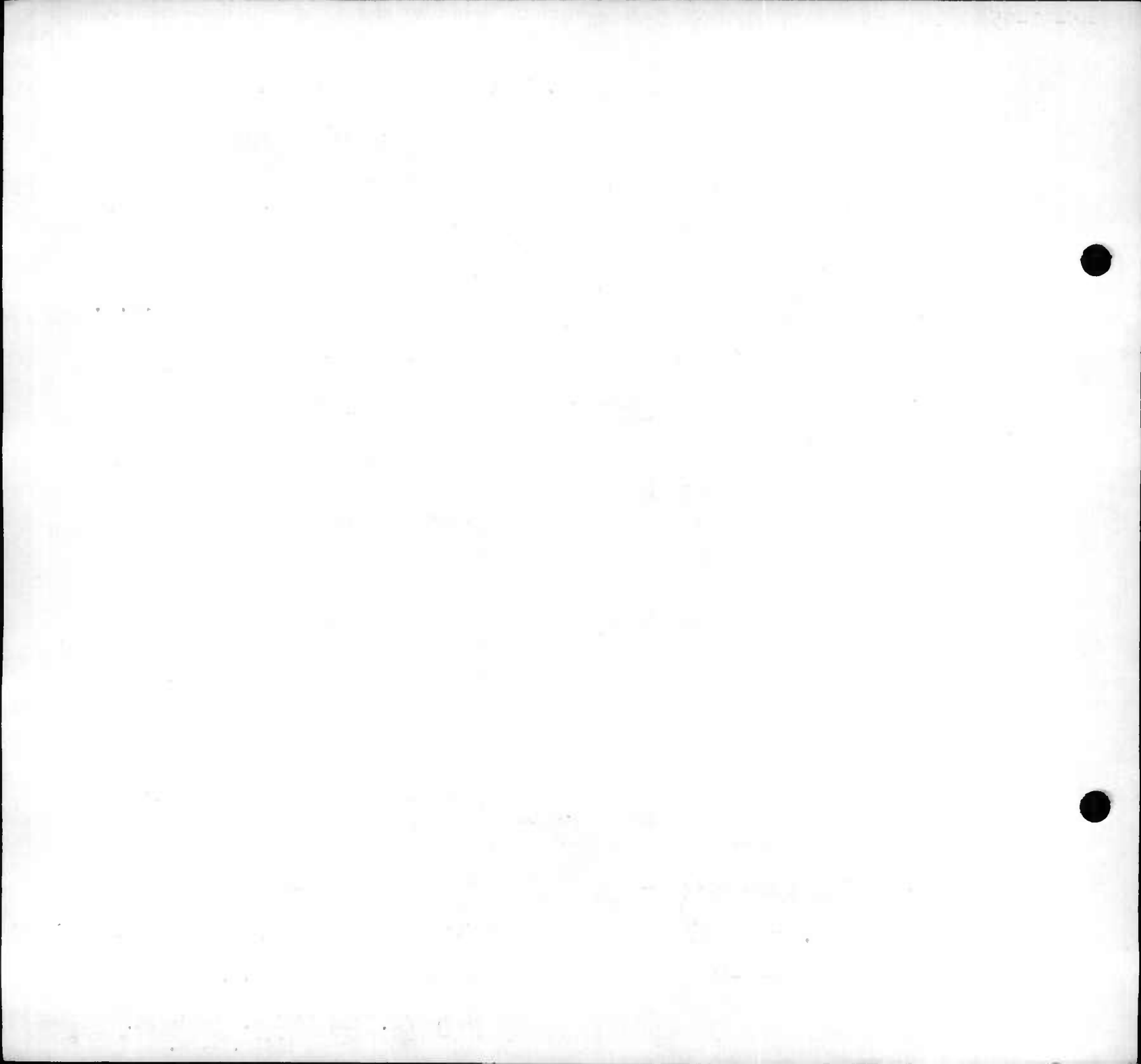
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00611	
BIRTH NO. 66 00611					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Katie Bundy (Bunday)			2. DATE AND HOUR OF DEATH January 18, 1966 11:35 a.m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street			4. USUAL RESIDENCE (If deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 15-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1515 N. Bruce Street		
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 10-6-1893	9. AGE (In years last birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ?? Baltimore, Maryland	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Hendricks 2121 1/2 McCulloh Street Sister in law	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH Hypertatic pneumonia Prolonged Non-ambulation Fracture, right femur		INTERVAL BETWEEN ONSET AND DEATH 18 Days
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Sister in law's home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2121 1/2 McCulloh St	
21D. TIME OF INJURY (APPROX.) 12 30 65		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? fell in bathroom 14-03	
22. I certify that (I) (this hospital) attended the deceased from December 31, 1965 to January 18, 1966 , that (I) (we) last saw the deceased alive on January 18, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Malabrigo			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-18-66
23C. PHYSICIAN'S NAME (Type) Joel A. Malabrigo			23D. ADDRESS M.D. 1514 Division Street		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-21-1966	24C. NAME OF CEMETERY or CREMATORY Baltimore National cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1966		25B. NAME OF REGISTRAR Joel A. Malabrigo		25C. FUNERAL DIRECTOR ADDRESS Arlington S. Phillips 1727 N. Monroe St.	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00612	
BIRTH NO. P-600 66 00612				CERTIFICATE OF DEATH	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>Charles Perry</i> (Charlie W. Perry)			1-18-66 4 19 M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Balto City Hospitals</i>			A. STATE <i>Balto. City</i> B. COUNTY <i>3-02</i>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto. Md</i>		
			D. STREET ADDRESS (If rural, give location) <i>1309 E. Baltimore St.</i>		
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Sep.</i>	8. DATE OF BIRTH <i>3-27-97</i>	9. AGE (In years last birthday) <i>68</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Longshoreman</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>William Perry</i>			14. MOTHER'S MAIDEN NAME <i>Lucretia Gee</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes World War I</i>		16. SOCIAL SECURITY NO. <i>218-10-0107</i>	17. INFORMANT ADDRESS <i>Records: BCH-4940 Eastern Avenue</i>		
18. <i>715-X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <i>Infected Decubital ulcers -</i> DUE TO (B) <i>Septicemia</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>14 months</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Generalized arteriosclerosis</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11/28/1965</i> 19 to <i>1/18/66</i> 19 that (I) (we) last saw the deceased alive on <i>1/18/66</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>J. Hernandez</i>			M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>1/18/66</i>
23C. PHYSICIAN'S NAME (Type) <i>V. Hernandez</i>			23D. ADDRESS M.O. <i>4940 Eastern Avenue, Baltimore, Maryland</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Removal</i>		24B. DATE <i>1-20-1966</i>		24C. NAME OF CEMETERY or CREMATORY <i>Beverly National Cemetery</i>	
				24D. LOCATION (City, town, or county) (State) <i>Beverly, N.J.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 19 1966</i>		25B. NAME OF REGISTRAR <i>Andrew W. Nix</i>		25C. FUNERAL DIRECTOR ADDRESS <i>1621 W. Dauphin St. Phila. 32, Pa.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

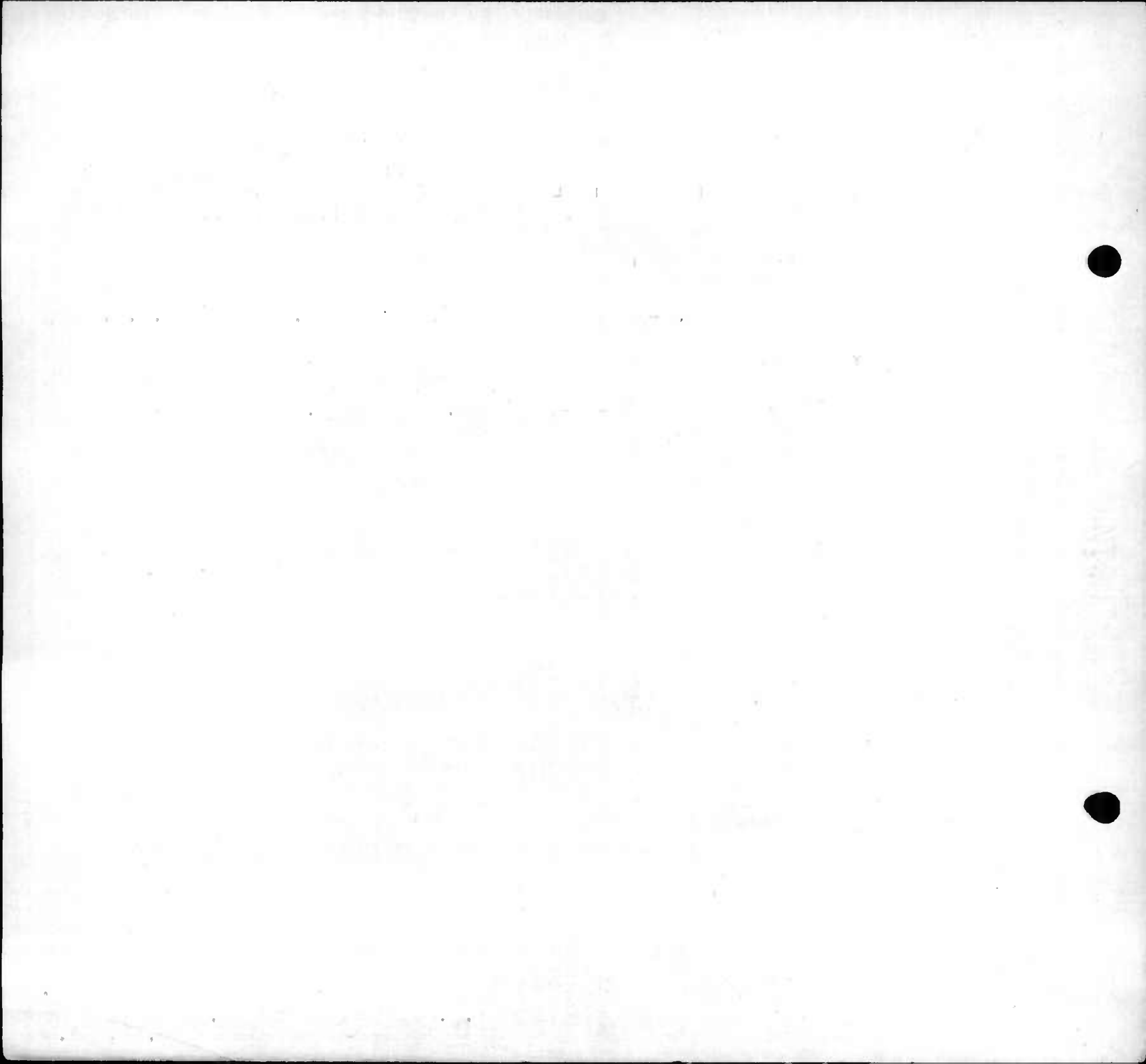
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00613	
BIRTH NO. 66 00613		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>ELIZABETH Amelia King</i>		2. DATE AND HOUR OF DEATH <i>1/16/66 2 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>27-18</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hosp</i>		D. STREET ADDRESS (If rural, give location) <i>517 Rossiter Ave</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>9/5/94</i>	9. AGE (In years last birthday) <i>71</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i>		11. BIRTHPLACE (State or foreign country) <i>BALTIMORE, Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>FRANKLIN RUPPERT</i>		14. MOTHER'S MAIDEN NAME <i>CATHERINE BUCKHEIT</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>216-071481B</i>		17. INFORMANT ADDRESS <i>MRS. MERLIE JOHNSON 2750 HARLAN AVE. (16)</i>	
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <i>Myocardial infarction</i> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1/15/66</i> 19 <i>66</i> to <i>1/16</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>1/16</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Paul Hudson Fesche</i> M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>Hudson Fesche</i> M.D.		23D. ADDRESS <i>UNION MEMORIAL HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>1/19/1966</i>	24C. NAME OF CEMETERY or CREMATORY <i>Loudon Park</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 19 1966</i>		25B. NAME OF REGISTRAR <i>H.W. Jenkins</i>		25C. FUNERAL DIRECTOR ADDRESS <i>H.W. Jenkins & Sons Co. 4905 York Road Baltimore 12, Md.</i>	

PAUL HINDS I. HECHE
JAN 11 1964

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 68 00614	
66 00614 CERTIFICATE OF DEATH											
BIRTH NO.		M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <i>Charles Hohman</i> (Charles Henry Hohman)						2. DATE AND HOUR OF DEATH <i>January 17, 1966 5:30 P.M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>27-11</i>					
FULL NAME OF HOSPITAL OR INSTITUTION <i>THE JOHNS HOPKINS HOSPITAL</i>						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>					
D. STREET ADDRESS (If rural, give location) <i>306 ROSSITER AVENUE</i>											
5. SEX <i>MALE</i>	6. RACE <i>WHITE</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>		8. DATE OF BIRTH <i>9-27-86</i>	9. AGE (In years last birthday) <i>79</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Engineer</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Self-employed</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>HENRY HOHMAN</i>						14. MOTHER'S MAIDEN NAME <i>BARBARA LITZ</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WW I</i>				16. SOCIAL SECURITY NO. <i>213-03-7965</i>		17. INFORMANT <i>Mrs. Florence L. Hohman</i>			ADDRESS <i>(Same)</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>420.1 I</i> (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH (A) <i>Acute Myocardial Infarction 24 hours</i> DUE TO (B) _____ DUE TO (C) _____			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <i>None</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>no</i>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 16</i> 19 <i>66</i> to <i>Jan 17</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Jan 17</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>Robert R. Kent</i> M.D.						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <i>Jan 17, 1966</i>		
23C. PHYSICIAN'S NAME (Type) <i>Robert R. Kent</i>						23D. ADDRESS <i>Johns Hopkins Hospital</i> M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/21/1966</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arlington National</i>				24D. LOCATION (City, town, or county) (State) <i>Arlington Va.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 19 1966</i>				25B. NAME OF REGISTRAR <i>W. Jenkins</i>				25C. FUNERAL DIRECTOR <i>H. W. Jenkins & Sons Co.</i> ADDRESS <i>4905 York Road Balto. 12, Md.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 00615	
BIRTH NO. 66 00615		M.E. CASE NO. 66 00615		1. NAME OF DECEASED (Type or Print) Williams, George Huntington		2. DATE AND HOUR OF DEATH 1-17-66 6:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND 44 Union Memorial Hospital Baltimore Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Baltimore B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 Union Memorial Hospital Baltimore Maryland				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Maryland			
D. STREET ADDRESS (If rural, give location) 205 Wendover Road Baltimore Maryland				5. SEX Male		6. RACE Caucasian	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single		8. DATE OF BIRTH 2/14/30		9. AGE (In years, lost birthday) 35		10. If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10B. KIND OF BUSINESS OR INDUSTRY RESEARCH		11. BIRTHPLACE (State or foreign country) Baltimore MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert W. Williams				14. MOTHER'S MAIDEN NAME Helen Gibbs			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 1951-1953				16. SOCIAL SECURITY NO. 024-76-9025		17. INFORMANT ROBERT W. WILLIAMS	
18. 05341 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) Cardiac Arrest DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Left Lung Atelectasis massive DUE TO			
				(C) Generalized Peritonitis and Septicemia.			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 1-15-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED peritonitis & tuberculous abscess		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) W		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) W		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> W		21F. HOW DID INJURY OCCUR? nil			
22. I certify that (this hospital) attended the deceased from Dec. 3, 1965 to Jan. 17, 1966, that (I/we) last saw the deceased alive on Jan. 17, 1966 and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/We) (did) (did not) view the body after death.							
23A. SIGNATURE Kang Fan				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-17-66	
23C. PHYSICIAN'S NAME (Type) KANG FAN				23D. ADDRESS Union Memorial Hospital Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/19/1966		24C. NAME OF CEMETERY or CREMATORY Greenmount		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1966		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.			

Central Street
East of North Street
Remains of the old
city wall

OK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 00616</u>	
BIRTH NO. <u>66 00616</u>				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Anton Hatle</u>			
2. DATE AND HOUR OF DEATH <u>January 16, 1966</u> <u>11 P.</u> M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>27-12</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Harford Gardens Nursing Home</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>5906 Brackenridge Ave.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan. 11, 1879</u>	9. AGE (In years last birthday) <u>87</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor-Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Haas Tailoring Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Bihop, Czechoslovakia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Frank Hatle</u>		14. MOTHER'S MAIDEN NAME <u>Anna Polenska</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-01-8103</u>		17. INFORMANT <u>Henry F. Hatle</u> ADDRESS <u>(Same)</u>	
18. <u>443X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Bronchopneumonia</u> DUE TO		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>Arteriosclerosis Cardio Vascular</u> <u>Disease - Hypertension</u> DUE TO				<u>13 mo</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Cerebral Thrombosis - Hemiplegia</u>				<u>10 mo</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Dec 8</u> 19 <u>64</u> to <u>Jan 16</u> 19 <u>66</u> , that (I) (we) lost saw the deceased alive on <u>January 15</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Charles W. Edmonds</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>Jan 18 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>Charles W. Edmonds</u>		23D. ADDRESS M.D. <u>2746 The Alameda</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/19/1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>Bohemian Cemetery of the Grand Lodge, C.S.P.S.</u>	
24D. LOCATION <u>Baltimore</u>		24E. (City, town, or county) (State) <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1966</u>		25B. NAME OF REGISTRAR <u>R. E. Jenkins</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u> ADDRESS <u>4905 York Rd. Balto. 12, Md.</u>	

FUNERAL DIRECTOR: IMPORTANT

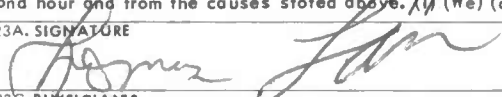
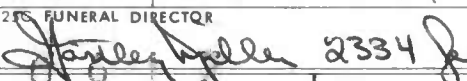
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

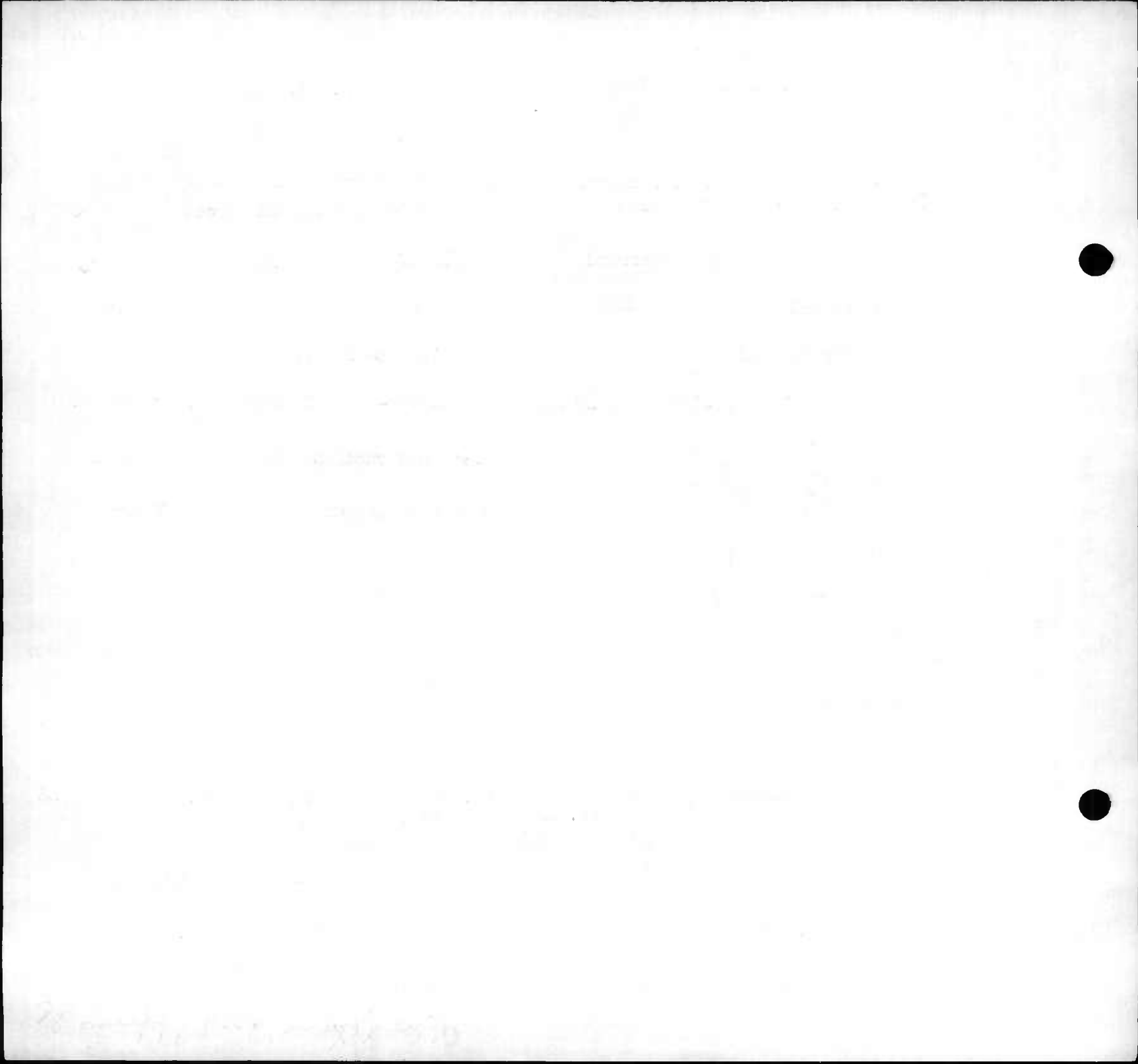
BIRTH NO. 66 00617				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 00617	
1. NAME OF DECEASED (Type or Print) MARJORIE GALLAGHER				2. DATE AND HOUR OF DEATH 18-JAN-66 6:30 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL 1-25-66				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE MARYLAND D. STREET ADDRESS (If rural, give location) 205 Rodgers Forge Rd					
5. SEX Female	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 10/1/96	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MARION MCKEE				14. MOTHER'S MAIDEN NAME GRACE HAWKINS					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes No				16. SOCIAL SECURITY NO. 220-22-9916		17. INFORMANT W. STARR GALLAGHER		ADDRESS 8400 NW 205 Rodgers Forge Rd -	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Cerebral Vascular Accident				CAUSE OF DEATH (A) DUE TO Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 8 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertension									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notably medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from 10-JAN-1966 to 18-JAN-1966 , that (1) (we) last saw the deceased alive on 18-JAN-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE T.C. Cullis				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 18-JAN-66			
23C. PHYSICIAN'S NAME (Type) T.C. Cullis MD				23D. ADDRESS MARYLAND GENERAL Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/20/1966		24C. NAME OF CEMETERY OR CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore Maryland			
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1966		25B. NAME OF REGISTRAR G.E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

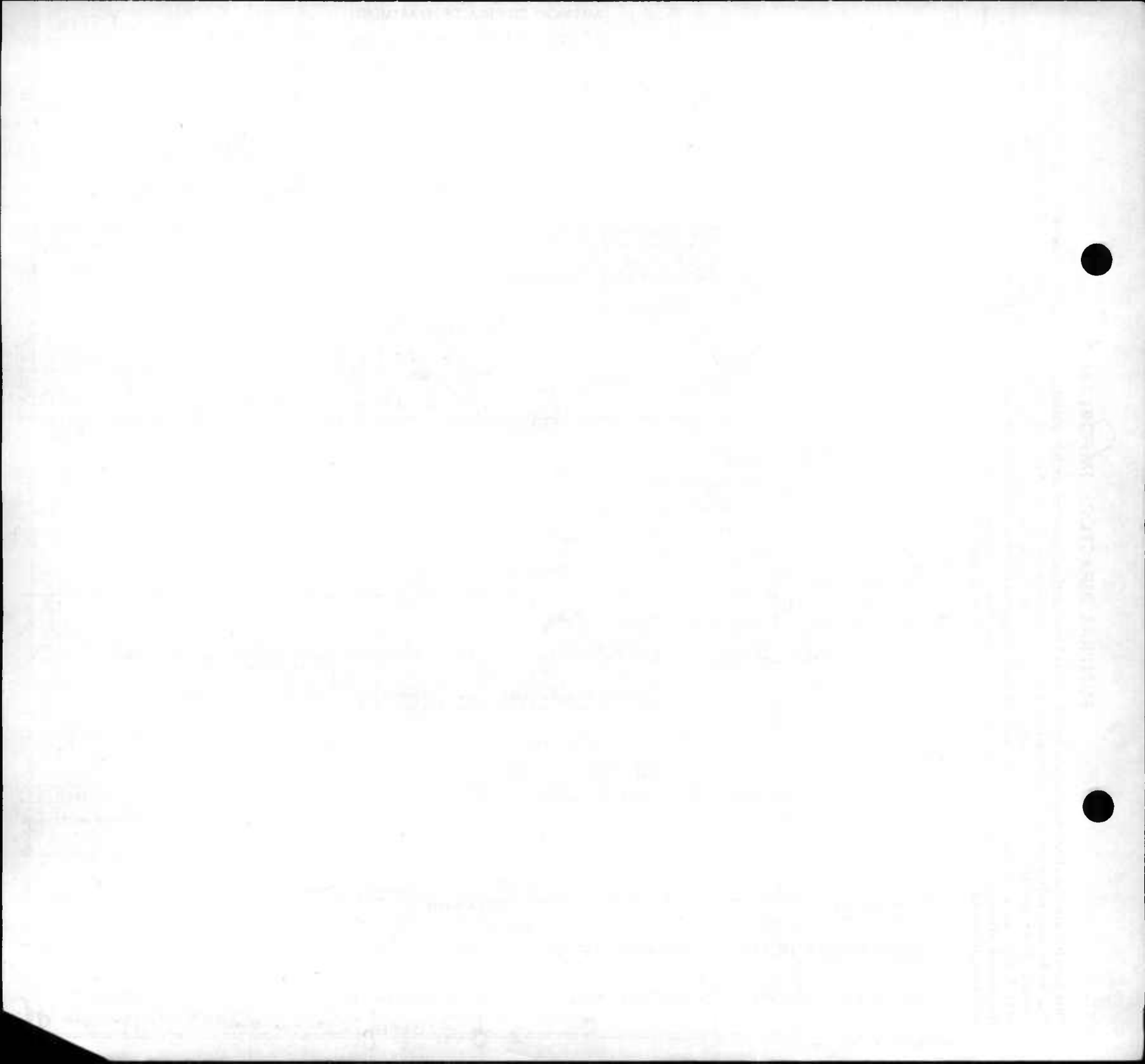
BALTIMORE CITY HEALTH DEPARTMENT										
66 00618 CERTIFICATE OF DEATH					Registered No. 66 00618					
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) HARRY WILLIAM BELL					2. DATE AND HOUR OF DEATH Jan. 15, 1966 6:25 P M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Pk. Drive & 31st Street					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 7-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2639 E. Monument Street					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12/11/14	9. AGE (In years last birthday) 51	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DC retired			10B. KIND OF BUSINESS OR INDUSTRY USN		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Harry E. Bell					14. MOTHER'S MAIDEN NAME Elizabeth Zahn					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes USN 1942-1962			16. SOCIAL SECURITY NO. 218-01-4239		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.					
18. 161 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Tracheal obstruction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Carcinoma of larynx					INTERVAL BETWEEN ONSET AND DEATH Months					
					Years					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from Dec. 28 1965 to Jan. 15 1966, that (1) (we) last saw the deceased alive on Jan. 15 1966 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.										
23A. SIGNATURE  M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED 1/17/66					
23C. PHYSICIAN'S NAME (Type) Thomas J. Lau, Surgeon (R)					23D. ADDRESS M.D. US PHS Hospital, Balto, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-20-66		24C. NAME OF CEMETERY or CREMATORY BALTO. NATIONAL CEM.		24D. LOCATION (City, town, or county) (State) BALTO. MD.				
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1966			25B. NAME OF REGISTRAR R. E. J. LAU			25C. FUNERAL DIRECTOR 			ADDRESS 2334 Jefferson St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

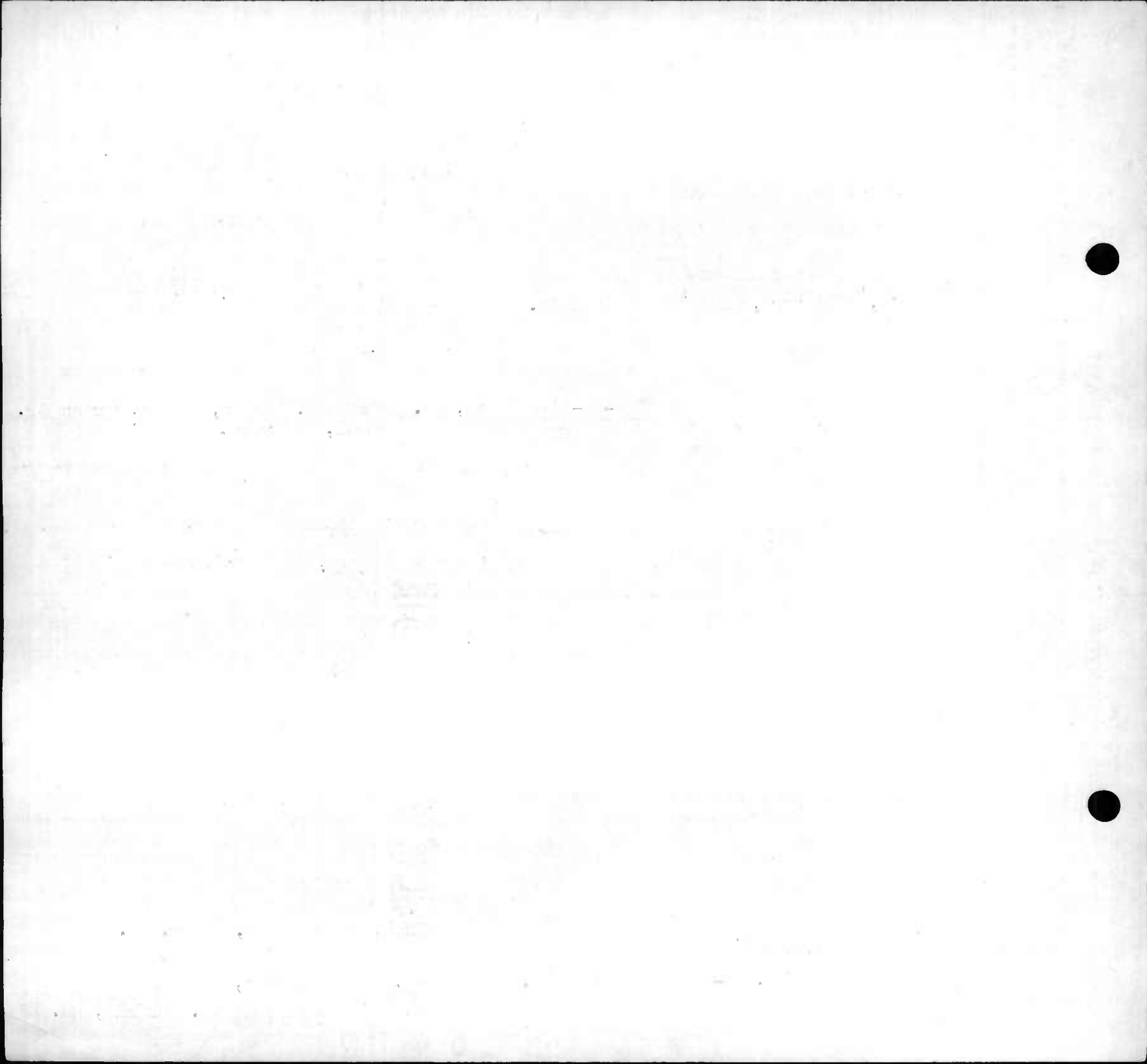
BALTIMORE CITY HEALTH DEPARTMENT										
66 00619					66 00619					
BIRTH NO.					CERTIFICATE OF DEATH					
M.E. CASE NO.					Registered No.					
1. NAME OF DECEASED (Type or Print) ELIZABETH PFEFFER					2. DATE AND HOUR OF DEATH 1-15-66					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION GOULD CONVALESCENT HOME					A. STATE MARYLAND					
(If not in hospital or institution, give street address or location)					B. COUNTY 6-01					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE					
					D. STREET ADDRESS (If rural, give location) 2 N. DECKER AVE.					
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3-23-1880	9. AGE (In years last birthday) 85	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) GERMANY			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN PARR					14. MOTHER'S MAIDEN NAME MARTHA —					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. Wilhelm Pfeffer - 2 N. Decker Ave					
18. 450.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) arteriosclerosis					CAUSE OF DEATH (A) arteriosclerosis (B) arteriosclerosis (C) arteriosclerosis					
19. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia, bilateral					INTERVAL BETWEEN ONSET AND DEATH 4 years					
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from July 1963 to Jan 12 1966 , that (I) (we) last saw the deceased alive on Jan 13 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Ronald V. Saw					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 1/17/66		
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS 55-00 Bawls Lane, Balto. Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 1-18-66		24C. NAME OF CEMETERY or CREMATORY MT. OLIVET CEMETERY			24D. LOCATION (City, town, or county) (State) BALTO. MD.		
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1966			25B. NAME OF REGISTRAR W. J. Galt			25C. FUNERAL DIRECTOR Harley Miller - 2334			ADDRESS Jeffers	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

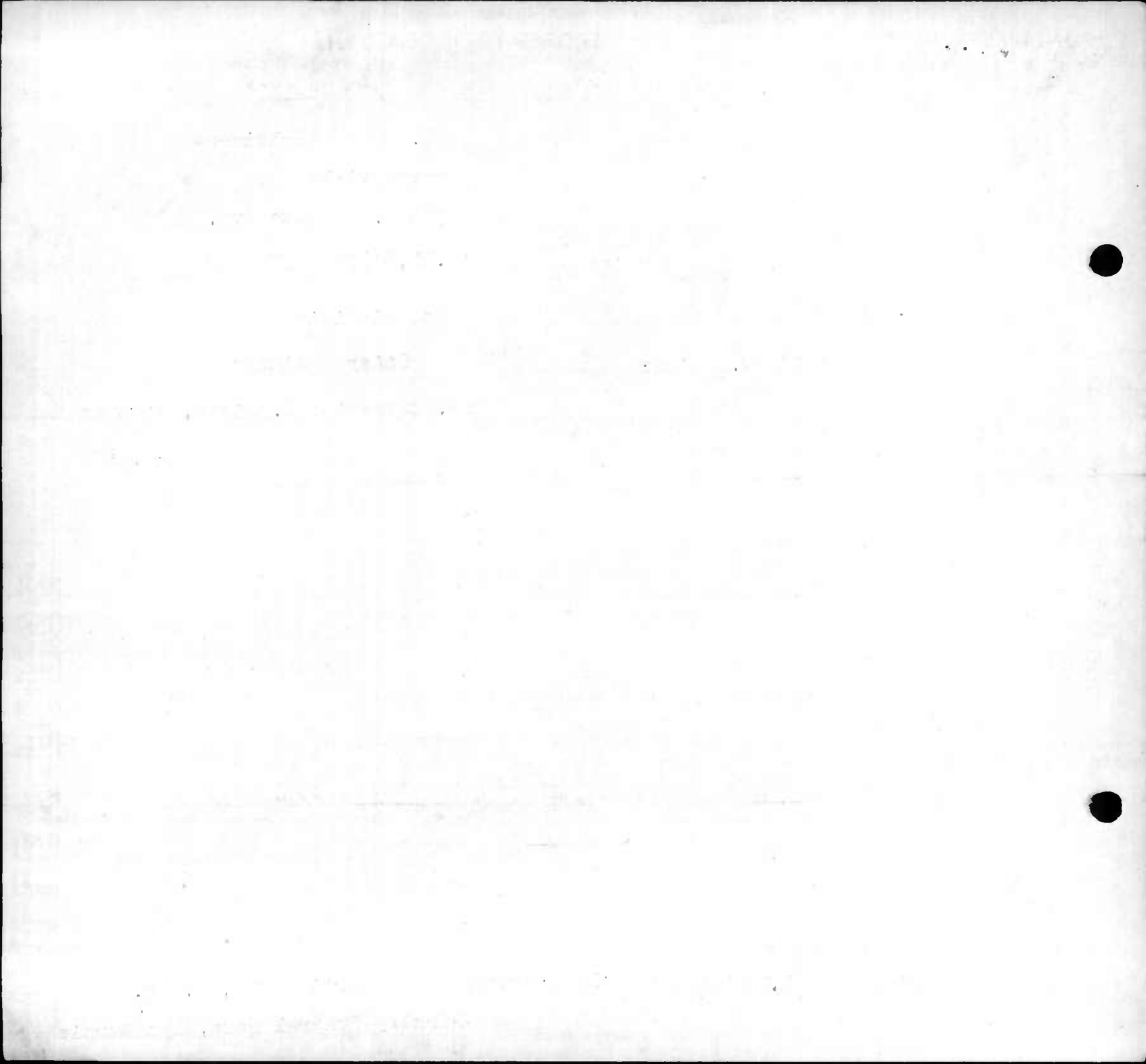
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>66 00620</u>	
BIRTH NO. <u>66 00620</u>		M.E. CASE NO. <u>WALTER M. MORGAN</u>		2. DATE AND HOUR OF DEATH <u>1/17/66</u> <u>12:40</u> P.M.			
1. NAME OF DECEASED (Type or Print) <u>MORGAN, WALTER</u>							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>46 Lutheran Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>15-11</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>Ashburton Nursing Home</u> <u>Hilton St</u> <u>3520</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>3-27-82</u>	9. AGE (In years last birthday) <u>83</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired, Shipyard, Bethlehem Steel Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired, Shipyard, Bethlehem Steel Co.</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Morgan</u>				14. MOTHER'S MAIDEN NAME <u>Not known</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-07-1485</u>		17. INFORMANT <u>Son, Mr. Dwinton D. Morgan, 108 Evergreen Dr.</u>			
18. <u>43441</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <u>Uremia</u> DUE TO (B) <u>GI bleeding</u> DUE TO (C) <u>heart disease, Aspiration pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-6-66 ~ 1-17-66</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1-12-66</u> to <u>1-17-66</u> and that (I) (we) last saw the deceased alive on <u>1-17-66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Cheung Sso Shin</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1-17-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>CHEUNG S. SHIN</u>				23D. ADDRESS <u>M.D. Lutheran Hospital, Balto. Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Jan. 20-1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>Jessup Meth. Church Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Cockeysville, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1966</u>		25B. NAME OF REGISTRAR <u>John J. Duda</u>		25C. FUNERAL DIRECTOR ADDRESS <u>7922 Wise Ave. Dundalk, Md. 22</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00621	
66 00621				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Mr David W. Riner		Jan. 16 1966		3 30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
D.O.A. Lutheran Hospital 730 Ashburton St 21216		Md. Baltimore			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Catonsville BALLO			
		D. STREET ADDRESS (If rural, give location)			
		700 N. Augusta Ave.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days
M	W	Married	Oct. 11, 1913	52	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Clergyman			West Virginia		USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
David W. Riner			Daisy Aikens		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS
Yes Peace Time			Mrs. Catherine T. Riner, same as 4		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			
		Coronary Occlusion			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 19 49 to Jan. 19 66, that (I) (we) lost saw the deceased alive on Oct. 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Lester A. Wall Jr.				1/16/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
LESTER A. WALL JR.		1039 5X. Paul 5X 21202			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		1/19/66		Rosedale Cemetery	
				Martinsburg, W. Va.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 19 1966		Robert E. Johnson		Kirkley Funeral Home, Glen Burnie	



BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MELVIN JOURNEY

2. DATE AND HOUR PRONOUNCED DEAD

January 11, 1966 6:25 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Agnes Hospital DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Jessups

D. STREET ADDRESS (If rural, give location)

Route 32 Box 35 Annapolis Junction

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

divorced

8. DATE OF BIRTH

March 14, 1895

9. AGE (In years
last birthday)

70

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

farmer

10B. KIND OF BUSINESS OR INDUSTRY

farm

11. BIRTHPLACE (State or foreign country)

Savage Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Benjamin F. Journey

14. MOTHER'S MAIDEN NAME

Mary Harney

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown. (If yes, give war or dates of service))

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Louis Journey, Jessups Md

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple traumatic injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

U.S. 1 near Md. 32 intersection

21D TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
1 11 66 5:55

21E. INJURY OCCURRED

WHILE AT
m. WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

pedestrian struck by auto

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-12-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JAN 19 1966

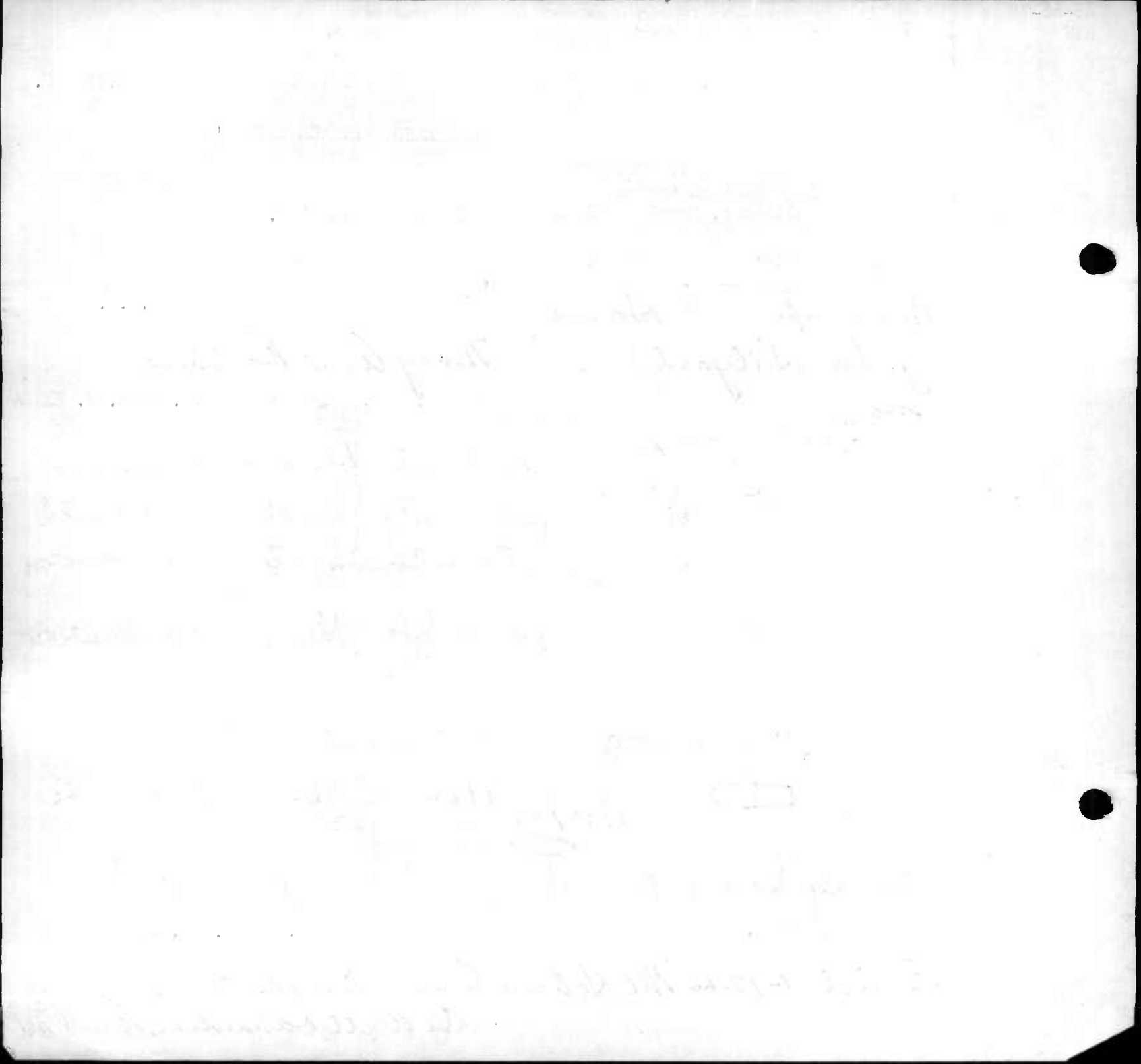
Robert E. Johnson

De Witt Davidson, Laurel Md

VALLEY FORD

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

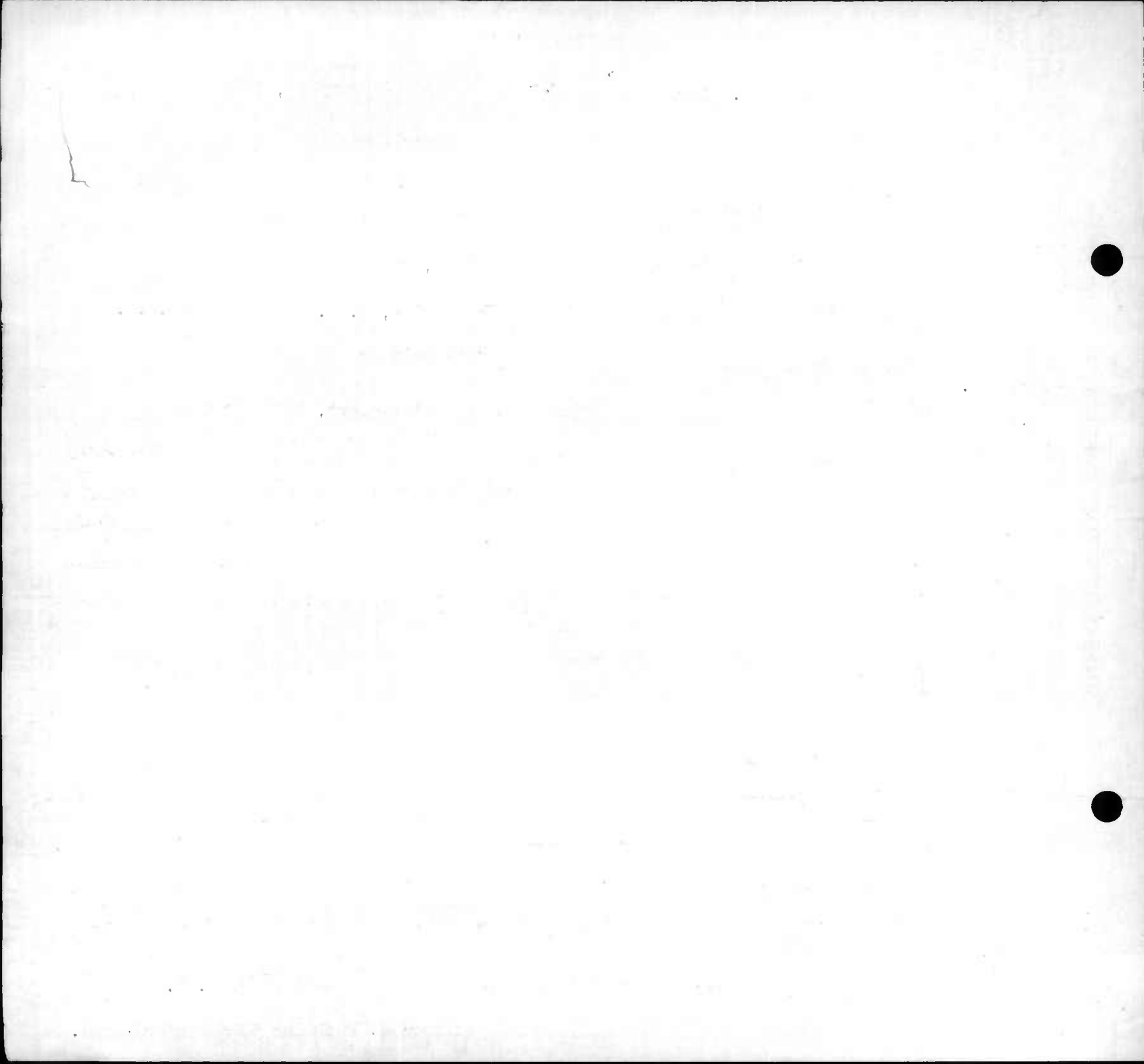
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00623	
BIRTH NO. B-320 66 00623		CERTIFICATE OF DEATH X			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) BETTIS, Suzie		1/13/66 2:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224		A. STATE MARYLAND B. COUNTY PRINCE GEORGE'S C. CITY OR TOWN (If outside city limits, write RURAL and give township) LAUREL D. STREET ADDRESS (If rural, give location) 319 Washington Blvd.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 8/10/91	9. AGE (In years last birthday) 74	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Hillyard			
14. MOTHER'S MAIDEN NAME Mary Ann Romaine		15. Was Deceased Ever in U. S. Armed Forces? (Yes or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS: BCH, 4940 Eastern Ave. Balto. Md. 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) asthmatic bronchitis		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO asthmatic bronchitis pulmonary embolism thrombophlebitis		INTERVAL BETWEEN ONSET AND DEATH 2 wks at death unknown	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. probable the		20. DATE OF OPERATION 1-17-66		21. CONDITION FOR WHICH OPERATION WAS PERFORMED No	
22. I certify that (I) (this hospital) attended the deceased from 1/12 1966 to 1/13 1966, that (I) last saw the deceased alive on 1/13/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Harry Dean Albert		23B. DATE SIGNED 1/13/66	
23C. PHYSICIAN'S NAME (Type) Harry Dean Albert		23D. ADDRESS M.D. 4940 Eastern Avenue, Balto. Md. - 21224		23E. MED. DIRECTOR X	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-17-66		24C. NAME OF CEMETERY OR CREMATORY Mt Lebanon Cem	
24D. LOCATION Winchester Virginia		24E. DATE REC'D BY HEALTH DEPT. JAN 19 1966		24F. NAME OF REGISTRAR Albert E. Taylor	
24G. FUNERAL DIRECTOR J. W. Witt		24H. ADDRESS Laurel Md		24I. DATE 1/13/66	



FUNERAL DIRECTOR: IMPORTANT

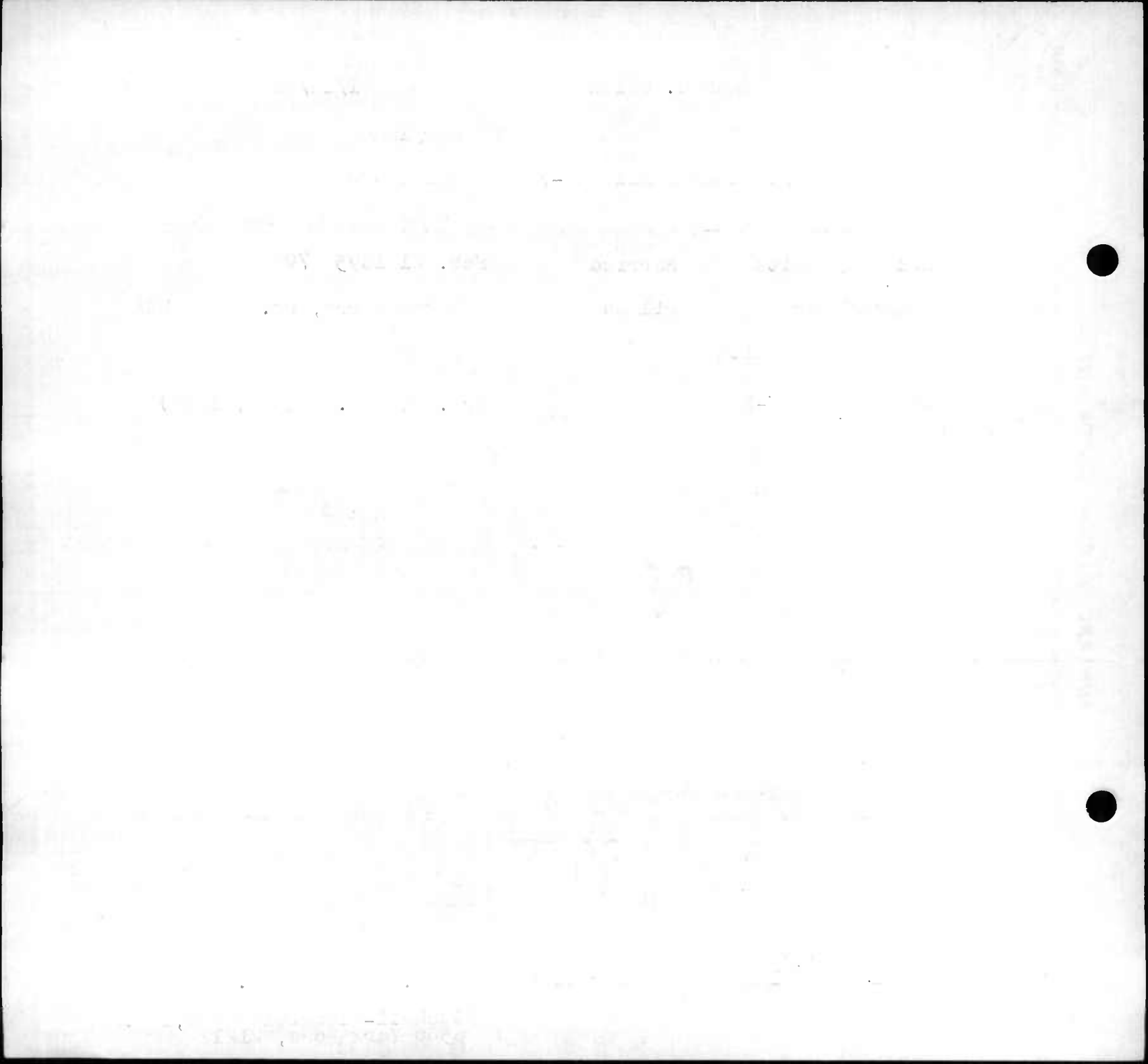
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00624		CERTIFICATE OF DEATH		Registered No. 66 00624	
1. NAME OF DECEASED (Type or Print) Rose C. King			2. DATE AND HOUR OF DEATH January 13, 1966 12³⁰ A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1230 Sheridan Avenue			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-09 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1230 Sheridan Avenue		
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH Nov 12, 1887	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Thomas Money		
14. MOTHER'S MAIDEN NAME Nora Kettner			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. NONE			17. INFORMANT Margaret Lambert, 1230 Sheridan		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction			INTERVAL BETWEEN ONSET AND DEATH 24 hrs		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Acute Pulmonary edema, severe			2 hrs		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 12 Jan 1966 to 13 Jan 1966 , that (I) (we) last saw the deceased alive on 13 Jan 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph F. LiPira M.D.			23B. DATE SIGNED 1-13-66		
23C. PHYSICIAN'S NAME (Type) Joseph F. LiPira M.D.			23D. ADDRESS 8400 Loch Raven Blvd. BALTO., Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-17-66		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
24D. LOCATION (City, town, or county) (State) SUTLAND, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 19 1966			
25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR Leonard J. Buck Inc 5305 Harford Road.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00625	
BIRTH NO. 66 00625		CERTIFICATE OF DEATH		66 00625	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		NATHAN C. SMITH		1/15/66 6:30 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
4611 Windsor Mill Rd-7		Maryland			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		4611 Windsor Mill Rd			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Oays: If Under 24 Hrs. Hours: Min.
Male	White	Married	Feb. 21 1895	70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Chauffeur		Oil Co		Wilkes Barre, Pa.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Ward Smith		Unknown		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		WW-1		Mrs. Mary F. Smith (Widow)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
260X I		CORONARY HEART DISEASE		? years	
ANTECEDENT CAUSES		(A) DUE TO CORONARY ATHEROSCLEROSIS			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO RIGHT HEMIPLEGIA - OLD		1 year	
		(C) DIABETES MELLITUS		? years	
II		None			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0 None				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-6 1963 to 1-15 1966, that (I) (we) last saw the deceased alive on 1-10 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Leon Aschman				1-18-66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		M.D. 5907 Fungus Oak Ave 21207			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1/19/66		Lorraine Park Cem.	
				24D. LOCATION (City, town, or county) (State)	
				Balto.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 19 1966		J. B. Smith		Mitchell-Wiedefeld Home, Inc. 6500 York Road, 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 66 00626					CERTIFICATE OF DEATH					Registered No. 66 00626				
1. NAME OF DECEASED (Type or Print) <i>Elizabeth Schmuff</i>					2. DATE AND HOUR OF DEATH <i>1/14/66</i> <i>8:00 a.m.</i>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Park Hill Nursing Home</i>					A. STATE <i>Maryland</i>					B. COUNTY <i>6-01</i>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>									
					D. STREET ADDRESS (If rural, give location) <i>15 N. Ellwood Avenue</i>									
5. SEX <i>Female</i>		6. RACE <i>White</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Never married</i>		8. DATE OF BIRTH <i>11/15/1868</i>		9. AGE (In years last birthday) <i>97</i>		If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY <i>Cont. Can. Co.</i>				11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Unknown</i>					14. MOTHER'S MAIDEN NAME <i>Unknown</i>									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>					16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Miss Anna Schmuff (Niece)</i>					ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>443 X I</i>					CAUSE OF DEATH (A) <i>Hypertensive and arterio-sclerotic heart disease</i> (B) <i>Arteriosclerotic brain disease</i> (C) _____					INTERVAL BETWEEN ONSET AND DEATH <i>chronic</i> <i>chronic</i>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.														
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION <i>0</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <i>No</i>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPRDX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>9/11</i> 19 <i>63</i> to <i>1/14</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>1/10</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <i>Laurie V. Blum M.D.</i>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED <i>1/14/66</i>				
23C. PHYSICIAN'S NAME (Type) <i>Laurie V. Blum M.D.</i>					23D. ADDRESS <i>3205 W. Rogers Ave. Balto. Md.</i>									
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>					24B. DATE <i>1/17/66</i>					24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore Cem.</i>				
										24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>				
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 19 1966</i>					25B. NAME OF REGISTRAR <i>04 42 56 10</i>					25C. FUNERAL DIRECTOR <i>Mitchell-Wiedefeld Home, Inc.</i>				
										ADDRESS <i>66500 York Rd. 21212</i>				

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00627	
BIRTH NO. 66 00627		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH 1-13-66 9.00 P.M.			
1. NAME OF DECEASED (Type or Print) KATHERINE FLOOKS		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 3123 WILLOUGHBY ROAD			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4-5-06	9. AGE (In years last birthday) 59	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secfy., Treas.		10B. KIND OF BUSINESS OR INDUSTRY Electric Co.		11. BIRTHPLACE (State or foreign country) New York State	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME PIERRE FISH			
14. MOTHER'S MAIDEN NAME Arethusa Poff		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 213-36-1370		17. INFORMANT ADDRESS Mr. Robert J. Flooks, Same as # 4			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 3.30 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Ruptured anterior communicating artery aneurysm. (B) DUE TO (C)			
INTERVAL BETWEEN ONSET AND DEATH		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 1-10-1966		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured aneurysm		20A. AUTOPSY (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-8-1966 to 1-13-1966, that (I) (we) last saw the deceased alive and at 9pm. 1-13-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Louie O Uematsu		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-13-66	
23C. PHYSICIAN'S NAME (Type) LOUIE O UEMATSU		23D. ADDRESS M.D. THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE Jan. 15, 1966		24C. NAME OF CEMETERY or CREMATORY Green Mount Crematory	
24D. LOCATION Baltimore City, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 20 1966			
25B. NAME OF REGISTRAR Robert E. Flocks		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson, 1050 York Road Towson 4, Md.			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00628	
66 00628				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		CLARA S. WHEATLEY		15 Jan. '66. 3:20 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		2/28/66		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION CERTIFICATE AMENDED <i>Fayette Convalescent Home</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>MD</i> B. COUNTY <i>BALTO.</i>	
5. SEX <i>Female</i>		6. RACE <i>White</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>		8. DATE OF BIRTH <i>17 May 86</i>		9. AGE (In years last birthday) <i>79</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>HOUSE WORK</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland (Balt. City)</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>JOHN BIGGS</i>		14. MOTHER'S MAIDEN NAME <i>EMILY GARDNER</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Mr Schiller 322 Stillwater Rd 21221</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <i>Bronchopneumonia</i>		<i>4d</i>	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>ASCVD, Cataracts, CRA</i>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>24 Nov 1964</i> to <i>15 Jan 1966</i> , that (I) (we) last saw the deceased alive on <i>15 Jan 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>J. Hulla</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>15 Jan 66</i>	
23C. PHYSICIAN'S NAME (Type) <i>J Hulla</i>		23D. ADDRESS <i>2214 E Fayette St 21231</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>1-18-66</i>		24C. NAME OF CEMETERY OR CREMATORY <i>OAK LAWN CEMETERY</i>	
24D. LOCATION (City, town, or county) (State) <i>7225 EASTERN BLVD. BALTO. MD</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 20 1966</i>		25B. NAME OF REGISTRAR <i>Charles J. Gailer</i>	
25C. FUNERAL DIRECTOR ADDRESS <i>901 S. CONKLING ST. BALTO., MD.</i>					

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
66 00629 CERTIFICATE OF DEATH					Registered No. 66 00629					
BIRTH NO.		M.E. CASE NO.			1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
					KATHERINE S. LORING			1. 17. 66 4 AM M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 Church Home Hospital					A. STATE Maryland, Baltimore					
					B. COUNTY					
					C. CITY OR TOWN (If outside city limits, write Rural and give township) Maryland 26-09					
					D. STREET ADDRESS (If rural, give location) 1004 S. Bayliss St.					
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widow		8. DATE OF BIRTH 11.17.81	9. AGE (In years last birthday) 84	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George Flury					14. MOTHER'S MAIDEN NAME Miri Jurg					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS John M. Loring 1004 S. Bayliss St. #24			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) 493 XI Pneumonia					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO					INTERVAL BETWEEN ONSET AND DEATH days
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1. 16. 66 19 to 1. 17. 66 19, that (I) (we) last saw the deceased alive on 1. 17. 66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE R. S. Magpantay					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) Rodolfo R. Magpantay					23D. ADDRESS Church Home Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-20-66		24C. NAME of CEMETERY or CREMATORY Sacred Heart Cemetery		24D. LOCATION (City, town, or county) (State) 7401 German Hill Rd. Balto. Md.				
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1966		25B. NAME OF REGISTRAR Robert E. Fisher			25C. FUNERAL DIRECTOR ADDRESS Charles J. Seiler 901 S. Conkling St. #24					

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 00630</u>	
BIRTH NO. <u>66 00630</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>LUCAS, MASON, CARLYLE,</u>			2. DATE AND HOUR OF DEATH <u>1/13/66</u> <u>10:35 P.M.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>MERCY HOSP.</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE <u>EAST WOOD</u> <u>5300</u> D. STREET ADDRESS (If rural, give location) <u>7020 Eastbrook Ave. #24</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>2/21/98</u>	9. AGE (In years last birthday) <u>68</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance man</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>SHERATON-BELVEDERE</u>		11. BIRTHPLACE (State or foreign country) <u>PEMBROKE, VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			13. FATHER'S NAME <u>LUCAS JOHN B. LUCAS</u>		
14. MOTHER'S MAIDEN NAME <u>CHARLOTTE ?</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>W.W.I</u>		
16. SOCIAL SECURITY NO. <u>213-10-1419</u>			17. INFORMANT <u>MARY C. LUCAS</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>C.V.A.</u>			19. CAUSE OF DEATH (A) <u>C.V.A.</u> (B) <u>diffuse A.S.C.V.D.</u> (C) _____		
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>probable myocardial infarct</u>			21. INTERVAL BETWEEN ONSET AND DEATH		
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>1/3</u> 19 <u>66</u> to <u>1/13</u> 19 <u>66</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>1/13</u> 19 <u>66</u> and that in (my) <u>(X)</u> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Maria Pia Calzini</u> M.D.				23B. DATE SIGNED <u>1/13/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>MARIA PIA CALZINI</u>				23D. ADDRESS <u>MERCY HOSP.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-17-66</u>		24C. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART CEM.</u>	
24D. LOCATION (City, town, or county) (State) <u>7401 GERMAN HILL RD. BALTO. CO. MD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1966</u>			
25B. NAME OF REGISTRAR <u>Charles E. Fidler</u>		25C. FUNERAL DIRECTOR <u>Charles E. Fidler</u>			
25D. ADDRESS <u>901 Franklin St. #24</u>					

JOHN B. ...
CHARLES ...
JOHN B. ...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66-00955 66 00631					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 66 00631				
1. NAME OF DECEASED (Type or Print) <i>GIRL Finnen</i>					2. DATE AND HOUR OF DEATH <i>JAN-18-66 3:00 A.M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Maryland General Hospital</i>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>24-03</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>1125 William St., 30</i>				
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>—</i>	8. DATE OF BIRTH <i>JAN-16-66</i>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
<i>—</i>			<i>—</i>		<i>Maryland</i>		<i>U.S.A.</i>		
13. FATHER'S NAME <i>Everett A. Finnen</i>					14. MOTHER'S/MAIDEN NAME <i>Alameda Barnes</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mother</i>				
<i>—</i>			<i>—</i>		<i>1125 William St. Baltimore, Md. 30</i>				
18. <i>773.51</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					CAUSE OF DEATH (A) <i>Respiratory Distress Syndrome</i> DUE TO (B) <i>PREMATURITY</i> DUE TO (C) <i>—</i>				
					INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>2 days</i>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>7/16/66</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>C-Section</i>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that the (this hospital) attended the deceased from <i>11:00 PM JAN 16 19 66</i> to <i>3:00 AM JAN 18 19 66</i> , that (I) (we) last saw the deceased alive on <i>JAN 18 19 66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Louis O. Olsen</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>1/18/66</i>		
23C. PHYSICIAN'S NAME (Type) <i>Louis O. Olsen</i>					23D. ADDRESS M.D. <i>Maryland General Hosp.</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>I 19 1966</i>		24C. NAME OF CEMETERY or CREMATORY <i>Meadowridge</i>		24D. LOCATION (City, town, or county) (State) <i>Dorsey, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 20 1966</i>			25B. NAME OF REGISTRAR <i>Robert E. ...</i>		25C. FUNERAL DIRECTOR <i>Mc Cully</i>		ADDRESS <i>130 E. Fort Ave</i>		

Mr. J. H. [illegible]

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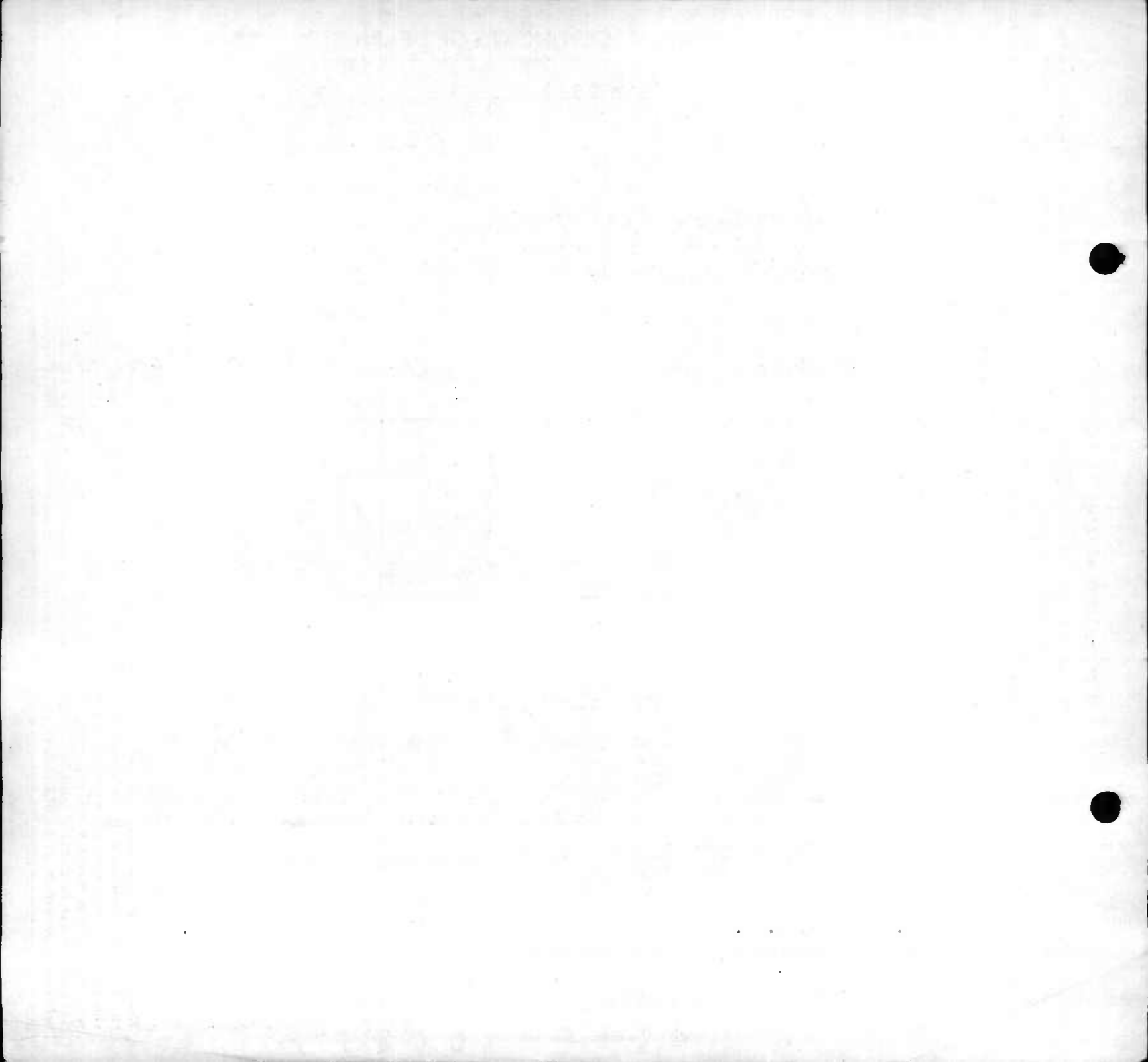
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>64-35800 66 00632</u>				CITY HEALTH DEPARTMENT		REGISTERED NO. <u>66 00632</u>	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Stella Cabezas</u>				2. DATE AND HOUR OF DEATH <u>1-18-66 10:30 P.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hosp.</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>Maryland</u>		B. COUNTY <u>25-05</u>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore #21225</u>			
				D. STREET ADDRESS (If rural, give location) <u>1134 Monroe Circle</u>			
5. SEX <u>F</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Single</u>	8. DATE OF BIRTH <u>12-25-1964</u>	9. AGE (In years last birthday) <u>1 yr.</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>Child</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Francisco Cabezas</u>				14. MOTHER'S MAIDEN NAME <u>Scicinko Elizabeth Zaszinko</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Fan. H</u>		ADDRESS <u>Same</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>493X I</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) <u>Pneumonia</u> (B) <u>Pericarditis</u> (C)		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Hypoprothrombinemia</u>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that the (this hospital) attended the deceased from <u>1-12</u> 19 <u>66</u> to <u>1-18</u> 19 <u>66</u> , that the (we) last saw the deceased alive on <u>1-18</u> 19 <u>66</u> and that in our (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>M. Behring</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1-18-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>M. Behrooz, M. D.</u>				23D. ADDRESS M.D. <u>South Baltimore General Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-20-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Hedonwidge</u>		24D. LOCATION (City, town, or county) (State) <u>Elkridge Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. ...</u>		25C. FUNERAL DIRECTOR <u>St. Cully funeral & 237 ...</u>		ADDRESS <u>...</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00633				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH X		Registered No. 66 00633	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				FUNK, LILLIE MAE		1-18-66		5:55A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY			
ST. AGNES HOSPITAL				MARYLAND		HOWARD			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
				ELKRIDGE					
				D. STREET ADDRESS (If rural, give location)					
				1935 FURNACE AVENUE					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. If Under 1 Yr. Months; Days	11. If Under 24 Hrs. Hours; Min.			
FEMALE	WHITE	MARRIED	2-24-18	47					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE						VIRGINIA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
HERMAN GOOD				ALICE WOOD					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO				?		Mr. Maury J. Funk, 1935 Furnace Ave. Elkridge, Md			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
237X I				Brain Tumor					
ANTECEDENT CAUSES				(A) DUE TO					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO					
				(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from JANUARY 10 19 66 to JANUARY 18 19 66, that (I) (we) last saw the deceased alive on JANUARY 18 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
Wenifredo N. Iglesias				1-18-66					
23C. PHYSICIANS NAME (Type)				23D. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		1-21-1966		Meadowridge		Elkridge, Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JAN 20 1966		R. E. E. E. E.		F. C. Higinbotham		Ellicott City, Md			

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 00634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 66 00634

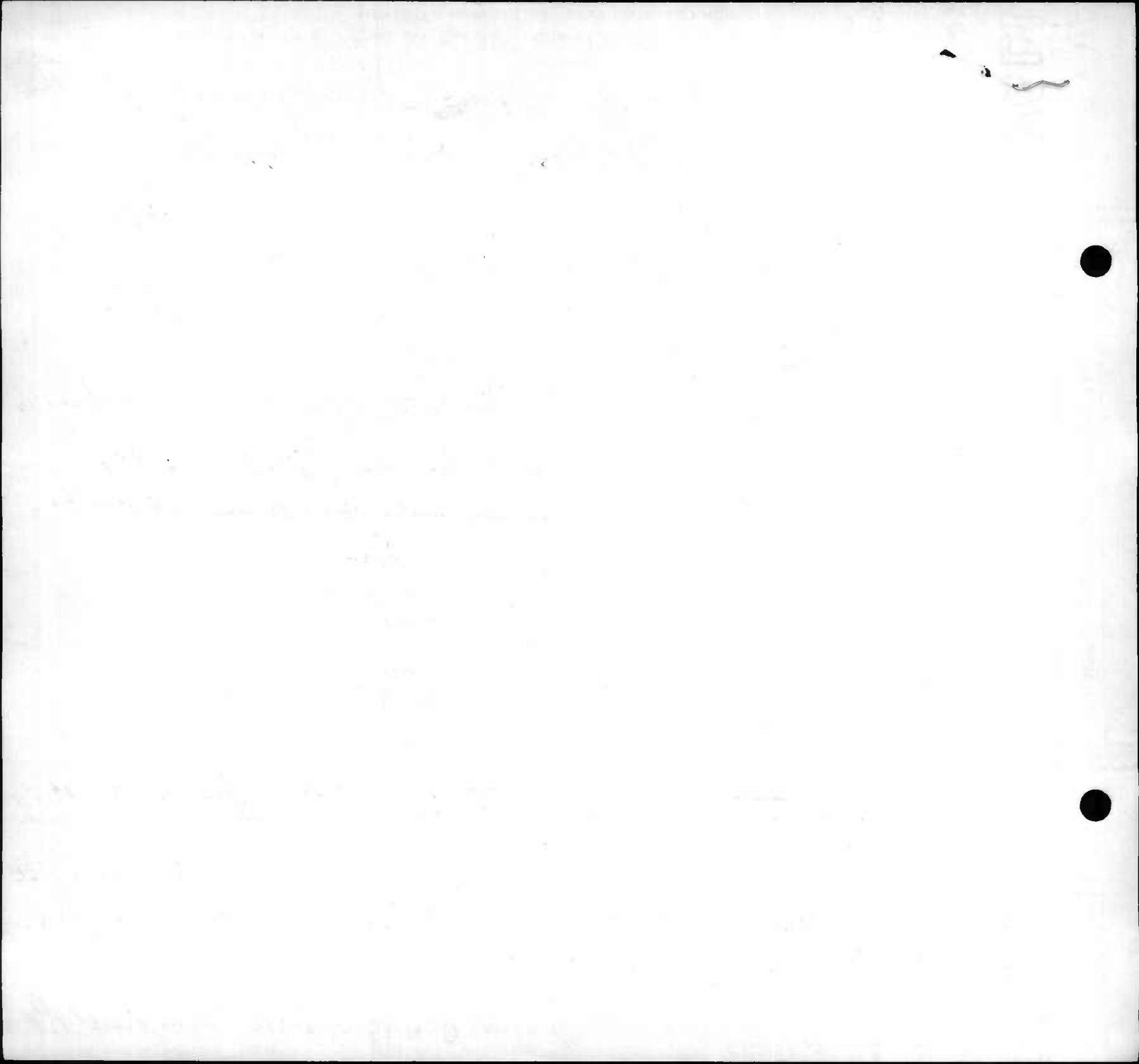
BIRTH NO.						NAME OF DECEASED						Registered No.					
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print)						2. DATE AND HOUR OF DEATH											
Louis EDWARD EANES						1-17-66						12:10 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY						MARYLAND, BALTIMORE 18-03					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)						C. CITY OR TOWN (If outside city limits, write RURAL and give township)						BALTIMORE					
UNIVERSITY HOSPITAL						D. STREET ADDRESS (If rural, give location)						10 South Poppleton Street					
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years lost birthday)		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.					
MALE		W		DIVORCED		1-10-11		54									
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?					
UNEMPLOYED				—				VIRGINIA				U.S.A.					
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME											
JOHN THOMAS EANES						MARY LOW BELCHEL											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS					
UNKNOWN BY						PATIENT						SAME					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO PULMONARY EDEMA MYOCARDIAL INFARCTION						INTERVAL BETWEEN ONSET AND DEATH 1/2 DAY 1/2 DAY					
MEDICAL CERTIFICATION						CERTIFICATION APPROVED BY CHIEF OR ASSIST. MEDICAL EXAMINER											
19A. DATE OF OPERATION						19B. CONDITION FOR WHICH OPERATION WAS PERFORMED						20A. AUTOPSY? (Yes or No)					
O —						—						NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)						21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)						21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)						21E. INJURY OCCURRED While At Work Not While At Work						21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1/17 1966 to 1/17 1966 that (we) last saw the deceased alive on 1/17 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view the body after death.																	
23A. SIGNATURE						23B. DATE SIGNED -											
Margaret E. Lang, M.D.						1/17/66											
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS											
MARGARET E. LANG						UNIVERSITY HOSPITAL, BALTIMORE, MD.											
24A. BURIAL CREMATION REMOVAL (Specify)						24B. DATE						24C. NAME OF CEMETERY or CREMATORY					
Removal						1/18/66						Hickory Grove Methodist					
24D. LOCATION (City, town, or county) (State)						25A. DATE REC'D BY HEALTH DEPT.						25B. NAME OF REGISTRAR					
Rockingham Co., Va.						JAN 20 1966						Wm. Cook Brooks Inc Baltimore, Md. 21202					

STANDARD INTERNATIONAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.


BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 00635					REGISTERED NO. 66 00635				
CERTIFICATE OF DEATH									
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH							
William J. Coplan		January 13, 1966 11 45 P. M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION 5002 Litchfield Ave		A. STATE Maryland B. COUNTY 27-18							
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore							
		D. STREET ADDRESS (If rural, give location) 5002 Litchfield Ave							
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
Male	White	Married	Dec 4, 1905	60					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Self-employed		Restaurant		Russia		765 A			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Jonas Caplan		Kore?							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
				Mrs Kate Caplan - 5002 Litchfield Ave					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH						INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) acute Myocardial Infarction						1 day	
ANTECEDENT CAUSES		(B) Atherosclerotic Heart Disease						15 months	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) none							
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
none									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
0				no					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (the hospital) attended the deceased from Oct 66 1964 to January 13 1966, that (I) (we) last saw the deceased alive on January 13 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED					
Manuel Levin				January 14, 1966					
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS							
MANUEL LEVIN		4818 Reisterstown Rd Balto Md.							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		Jan 14/66		Beth Tzedek		Woodlawn Md			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JAN 20 1966		R. E. J. [unclear]		Sal [unclear] [unclear]		2000 Reister Rd			



B-200 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00636				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00636	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BASS Jack.				2. DATE AND HOUR OF DEATH 1-19-66. 1AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL		(If not in hospital or institution, give street address or location) BBEVEDERE AVE AT GREENSPRING		A. STATE MARYLAND		B. COUNTY BALTIMORE	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 5527 Lynview AVE 21215			
5. SEX Male	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3-19-11	9. AGE (In years last birthday) 54	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR		10B. KIND OF BUSINESS OR INDUSTRY Cab Owner		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Morris Bass				14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-03-0969		17. INFORMANT Belle Bass			
				ADDRESS 5527 Lynview Ave Balto, 15 Md.			
18. 450.01				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO Mesenteric Thrombosis			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO Generalised atherosclerosis			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. HIATAL HERNIA							
19A. DATE OF OPERATION 1-11 and 1-18		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED HIATAL HERNIA, Post. O.P.		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that the (this hospital) attended the deceased from 12-27-65 19 to 1-19- 19 66 , that it (we) last saw the deceased alive on 1-19 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. It (We) (did) (did not) view the body after death.							
23A. SIGNATURE 				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/19/66	
23C. PHYSICIAN'S NAME (Type) Dr. V. Satyanarayana Rao				23D. ADDRESS SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/20/66		24C. NAME OF CEMETERY OR CREMATORY Workmen Circle Cemetery		24D. LOCATION (City, town, or county) (State) German Hill Road	
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1966		25B. NAME OF REGISTRAR P. E. Johnson		25C. FUNERAL DIRECTOR Sol. Lexinson & Bros		ADDRESS 6010 Reisterstown Rd.	

1st. 11-1-8 121484M 31114 1214

21114 1214

121484M 31114

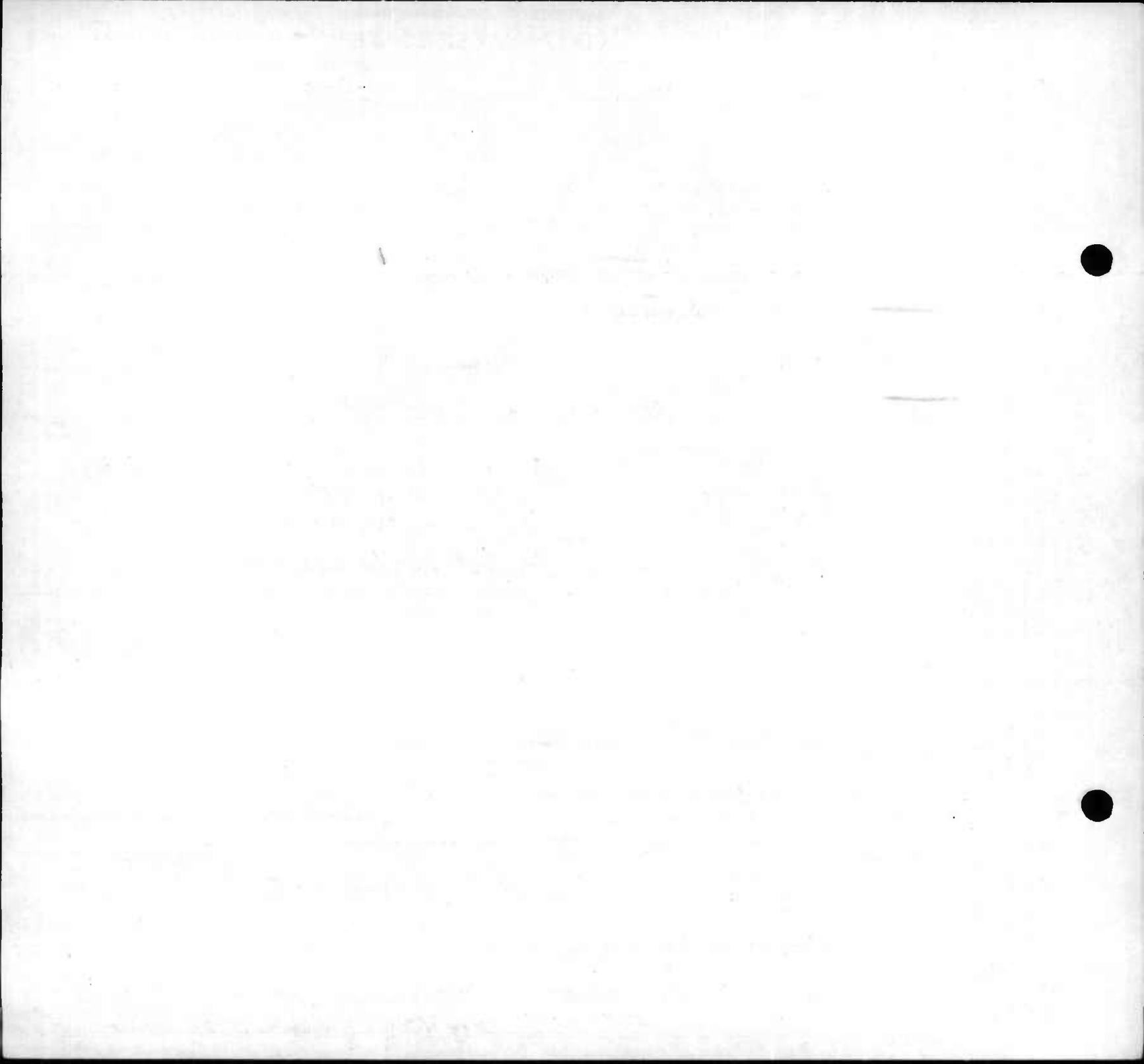
121484M 31114

121484M 31114

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

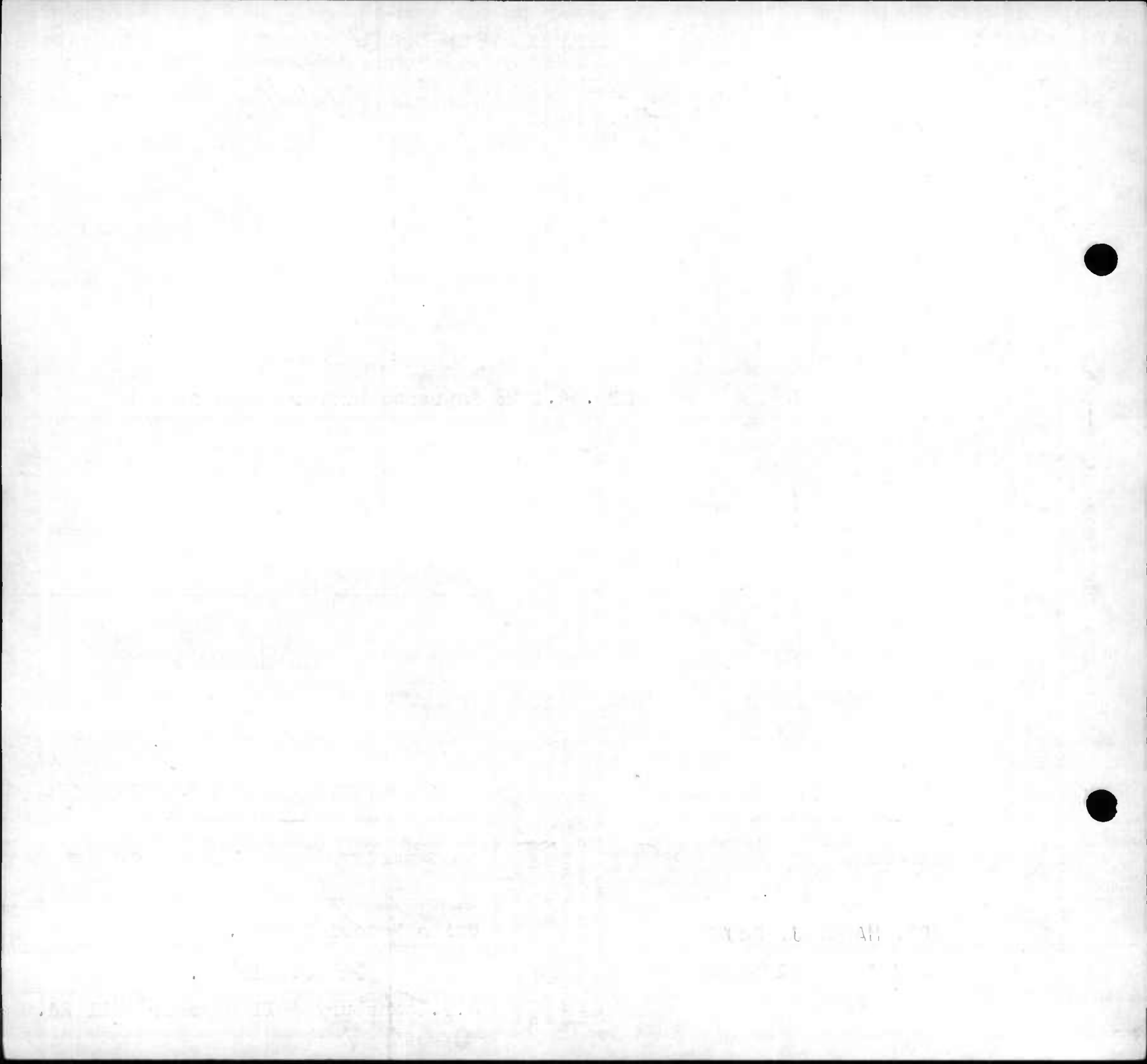
BALTIMORE CITY HEALTH DEPARTMENT																			
66 00637					CERTIFICATE OF DEATH					Registered No. 66 00637									
BIRTH NO.					M.E. CASE NO.					1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
					Price, Howard Milton					1-17-66					12:10 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION Bon Secours Hospital 2025 W. Fayette St Baltimore 23, Md.										A. STATE Md B. COUNTY Baltimore City C. CITY OR TOWN Baltimore D. STREET ADDRESS 412 S Pulaski St (23)									
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed		8. DATE OF BIRTH 10-21-1891		9. AGE (In years last birthday) 74		If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Guard					10B. KIND OF BUSINESS OR INDUSTRY Distillery					11. BIRTHPLACE (State or foreign country) Md					12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Joseph J. Price										14. MOTHER'S MAIDEN NAME Magnie Saunders									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown					16. SOCIAL SECURITY NO. 212-12-153A					17. INFORMANT Edna Pugh s me address					ADDRESS				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.1 I ACUTE MYOCARDIAL INFARCT OF POST. WALL OF LEFT VENTRICLE										CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH 2 days				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(B) Arteriosclerotic Ht. Disease					years				
										(C) Atelectasis + bronchiectasis					years				
II																			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION 2					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) yes					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from 1/11/66 to 1/17/66 and that (I) (we) last saw the deceased alive on 1/17/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE Gholamreza Pezeshkian										23B. DATE SIGNED 1/17/66					23C. PHYSICIAN'S NAME (Type) Gholamreza Pezeshkian				
23D. ADDRESS M.D. Bon Secours Hospital - Medical Clinic					23E. ADDRESS														
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial					24B. DATE 1/21/66					24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.					24D. LOCATION (City, town, or county) (State) Baltimore Md.				
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1966					25B. NAME OF REGISTRAR E. J. ...					25C. FUNERAL DIRECTOR John ...					ADDRESS 901 - Hallam St (23)				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

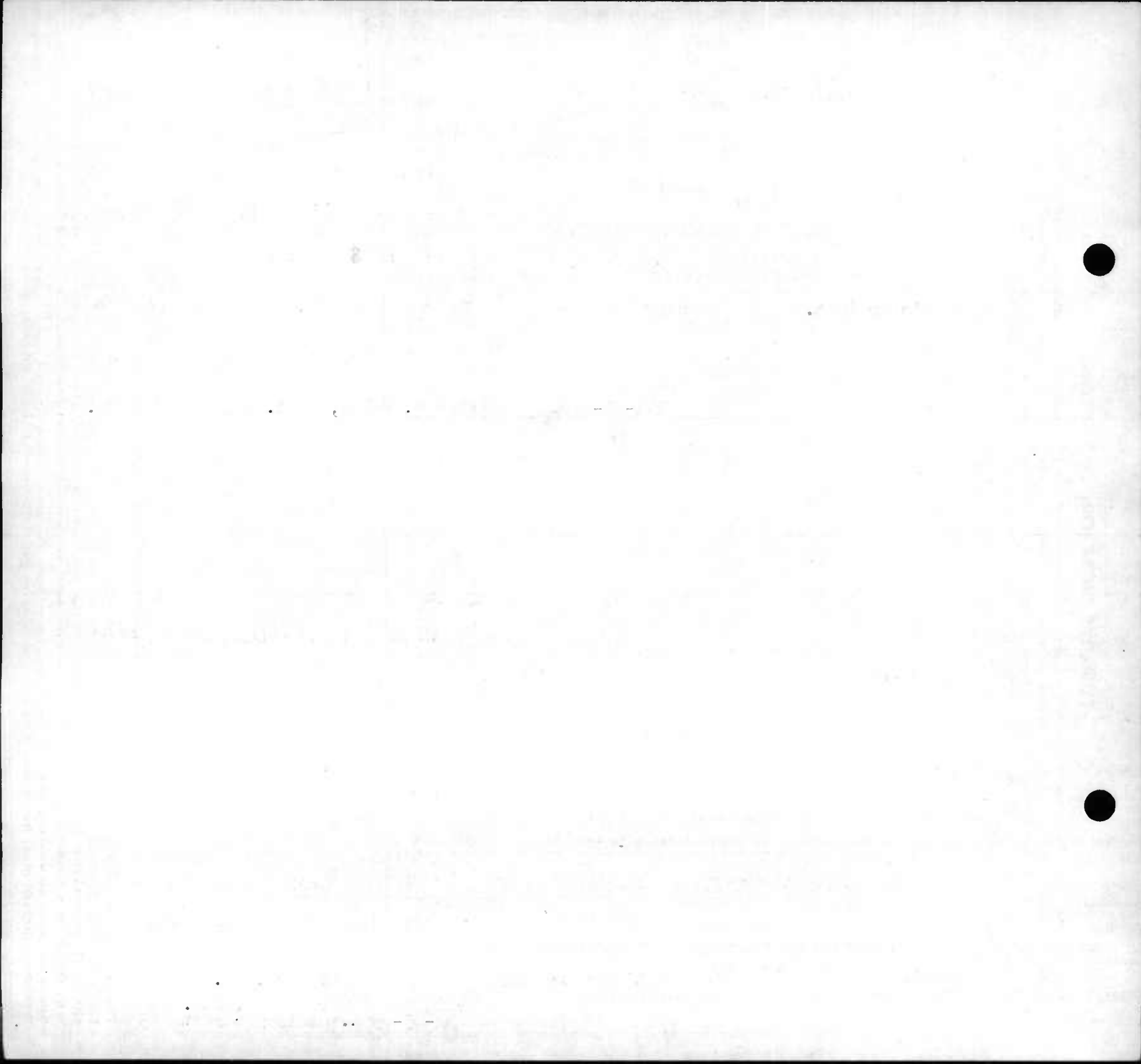
BALTIMORE CITY HEALTH DEPARTMENT											
BIRTH NO. 66 00638										Registered No. 66 00638	
CERTIFICATE OF DEATH											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) <u>Nellie E. Hubbard</u>						2. DATE AND HOUR OF DEATH <u>1/17/66</u> <u>3 P.</u> M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>Union Memorial Hospital</u> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>5370 31 Maryland Ave.</u>					
5. SEX <u>Female</u>		6. RACE <u>White</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>10/5/88</u>		9. AGE (In years last birthday) <u>77 yrs</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Morris</u>						14. MOTHER'S MAIDEN NAME <u>Serra, Sara</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>220.44.1328</u>		17. INFORMANT <u>Lawrence Hubbard Same as 4 D</u>				ADDRESS	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <u>Myocardial Infarction</u> DUE TO (B) _____ DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1/13/66-1/17/66</u>											
II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that <u>he</u> (this hospital) attended the deceased from <u>1/13/66</u> 19 <u>66</u> to <u>1/17/66</u> 19 <u>66</u> , that <u>he</u> (we) last saw the deceased alive on <u>1/17/66</u> 19 <u>66</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>He</u> (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>H. Brown</u>						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>1/17/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR. HARRY J. BROWN</u>						23D. ADDRESS M.D. <u>Union Memorial Hosp.</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>1/20/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Druid Ridge</u>				24D. LOCATION (City, town, or county) (State) <u>Pikesville Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1966</u>				25B. NAME OF REGISTRAR <u>John E. Stansbury</u>				25C. FUNERAL DIRECTOR <u>J.T. Stansbury</u> ADDRESS <u>6411 Windsor Mill Rd.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 00639			
BIRTH NO. 66 00639		M.E. CASE NO. 66 00639		1. NAME OF DECEASED (Type or Print) Augusta William Whitaker		2. DATE AND HOUR OF DEATH 1-18-66 1 12 M			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. 701 B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 814 N. Streeper St 21205					
5. SEX Male	6. RACE Caucasian	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 4-15-1878	9. AGE (In years last birthday) 87	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter (Ret.)		10B. KIND OF BUSINESS OR INDUSTRY Busky Brothers		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Howard Whitaker				14. MOTHER'S MAIDEN NAME Alice Hanson					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-03-8940		17. INFORMANT ADDRESS Helen M. Dolch, Dght. 127 Lyndale Ave. #36					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Marginal ulcer Chronic emphysema, ASCVHD				CAUSE OF DEATH (A) Branchopneumonia DUE TO ? (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH sev. weeks years			
				19A. DATE OF OPERATION 1-15-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED HERNIA, INGUIN		20A. AUTOPSY? (Yes or No) YES	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1-2-27 1965 to 1-18 1966, that (I) (we) last saw the deceased alive on 1-17 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Mary Jim Ratner MD				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-18-66			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D. Mercy Hospital Box 98					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/21/66		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1966		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 2601-03-05 E. Madison Street #5		ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 00640	
BIRTH NO. 66 00610		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MRS. LILLIAN T. ROBINSON		2. DATE AND HOUR OF DEATH 1-17-66 9.06 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL				A. STATE MARYLAND		B. COUNTY 1308	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 1335 W. 41st. St.			
5. SEX F	6. RACE W	7. MARITAL STATUS WIDOWED	8. DATE OF BIRTH 5-13-85		9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THOMAS J. SAUERHOFF				14. MOTHER'S MAIDEN NAME JULIA QUILLEN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Daughter in law Mrs. Frank Robinson		ADDRESS Hampstead Md.	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) Acute MYOCARDIAL INFARCT DUE TO PACEMAKER (EXTERNAL) INSERTED 1/15		4 DAYS	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. HACVD				20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
19A. DATE OF OPERATION 1/15/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CARDIAC CONDUCTION FAILURE		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 1/14 1966 to 1/17 1966, that (I) (we) last saw the deceased alive on 1/17 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Charles S. Brown				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/17/66	
23C. PHYSICIAN'S NAME (Type) CHARLES S. BROWN				23D. ADDRESS UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 20 Jan 66		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore County Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Burgee Funeral Home		ADDRESS 3631 Falls Road	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

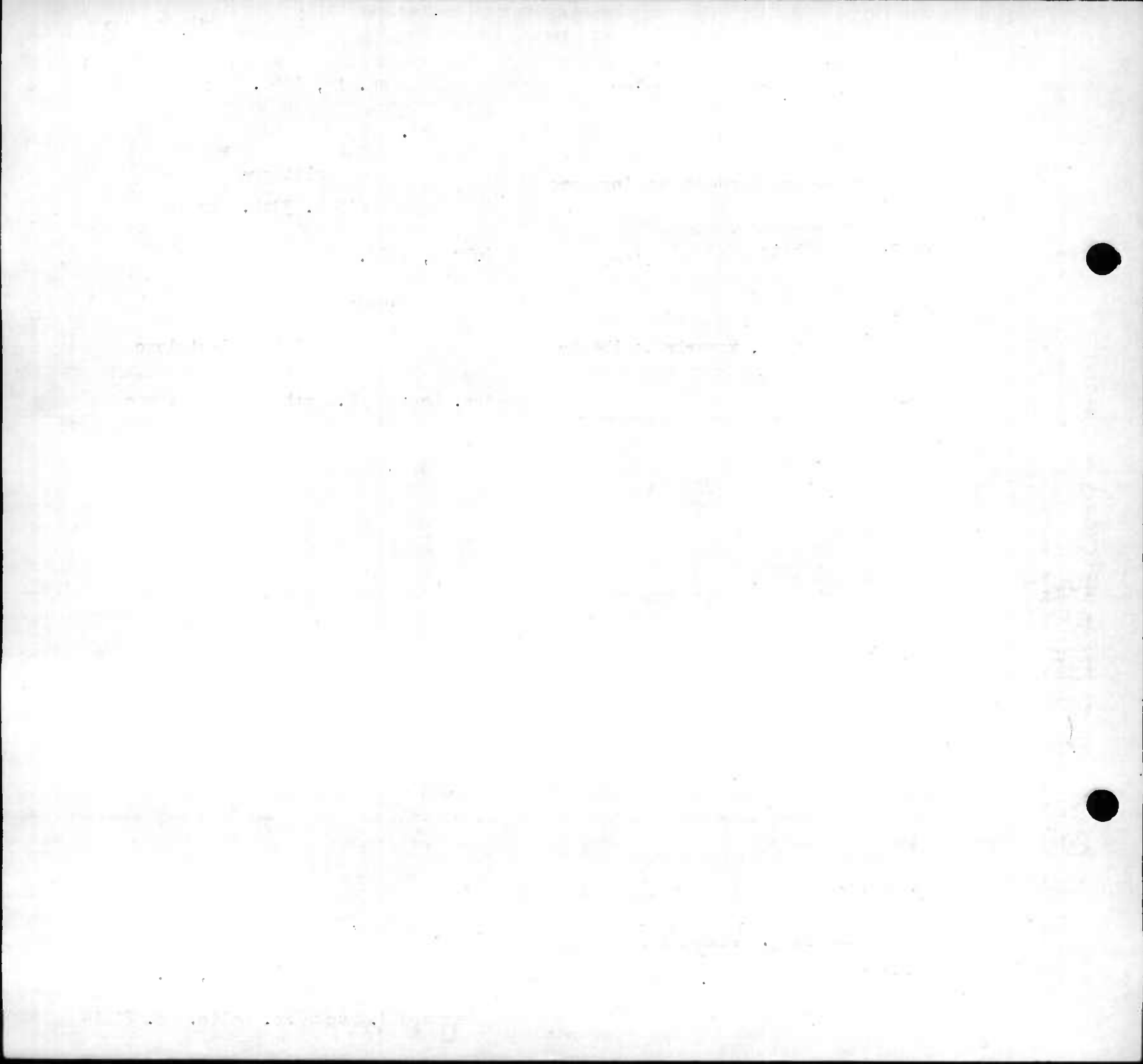
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH						Registered No. <u>66 00641</u>
BIRTH NO. <u>5-365</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Susie May Sterner</u>		2. DATE AND HOUR OF DEATH <u>January 18, 1966 8 A. M.</u>
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>The Union Memorial Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>27-14</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1029 Wood Heights Ave.</u>		
5. SEX <u>Female</u>	6. RACE <u>Caucasian</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>4/19/85</u>	9. AGE (In years last birthday) <u>80</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert D. Butcher</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Gosnell</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT ADDRESS <u>Mr. Harry Sterner</u>			
18. <u>581.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Terminal Cirrhosis of Liver</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Many Years</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that <u>she</u> (this hospital) attended the deceased from <u>December 22, 1965</u> to <u>January 18, 1966</u> , that <u>she</u> (we) last saw the deceased alive on <u>January 17, 1966</u> and that in <u>our</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>she</u> (We) (did) (did not) view the body after death.						
23A. SIGNATURE <u>A. C. Tipton, Jr.</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>1/18/66</u>
23C. PHYSICIAN'S NAME (Type) <u>A. C. TIPTON, JR.</u>		23D. ADDRESS M.D. <u>33rd + Calvert Streets</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>21 Jan 66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Woodlawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore County Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1966</u>		25B. NAME OF REGISTRAR <u>Robert C. Jones</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Burgee Funeral Home 3631 Falls Road</u>		

A. C. LIST

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 00642	
BIRTH NO. 66 00642				1. NAME OF DECEASED (Type or Print) Rose Taylor		2. DATE AND HOUR OF DEATH Jan. 18, 1966. 1:40 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Harford Gardens Nursing Home				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 9-04		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 615 E. 30th. Street				5. SEX Female 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow		8. DATE OF BIRTH July 3, 1896. 9. AGE (In years last birthday) 69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Canada	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Max J. LaLiberte LaLiberte			
14. MOTHER'S MAIDEN NAME Albina Dieutrivac				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS Mrs. Lorena M. Toth (Same)			
18. 450.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) INTERSELEBRON'S ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Apr 6 1965 to Jan 18 1966 , that (I) (we) last saw the deceased alive on Jan 7 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE William E. Helfrich M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 1-19-66			
23C. PHYSICIAN'S NAME (Type) William E. Helfrich				23D. ADDRESS 5006 Roland Ave - Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 1/21/66.			
24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery				24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1966				25B. NAME OF REGISTRAR Robert E. ...			
25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.				ADDRESS Balto. Md. 21214			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>66 00643</u>	
BIRTH NO. <u>66 00643</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Ella Chilcote</u>		2. DATE AND HOUR OF DEATH <u>Jan. 17, 1966</u> <u>9:00 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>2811 Fleetwood Avenue</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>2811 Fleetwood Avenue</u>			
5. SEX <u>female</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>Jan. 13, 1886</u>	9. AGE (In years last birthday) <u>80</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Chalk</u>				14. MOTHER'S MAIDEN NAME <u>Josephine T. Carter</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-26-1928</u>		17. INFORMANT <u>Mrs. Elizabeth M. Weichseldorfer</u>		ADDRESS <u>Same</u>	
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u> II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic Cardiovascular Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>20 yrs.</u>			
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> 19 <u>62</u> to <u>Jan</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12 Jan</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Thomas J. Brennan</u> M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>18 Jan 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>Thomas J. Brennan</u>				23D. ADDRESS <u>5217 Harford Road Balto Md 21214</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/20/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Sullivan</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Buck Inc 5305 Harford Road #14</u>			

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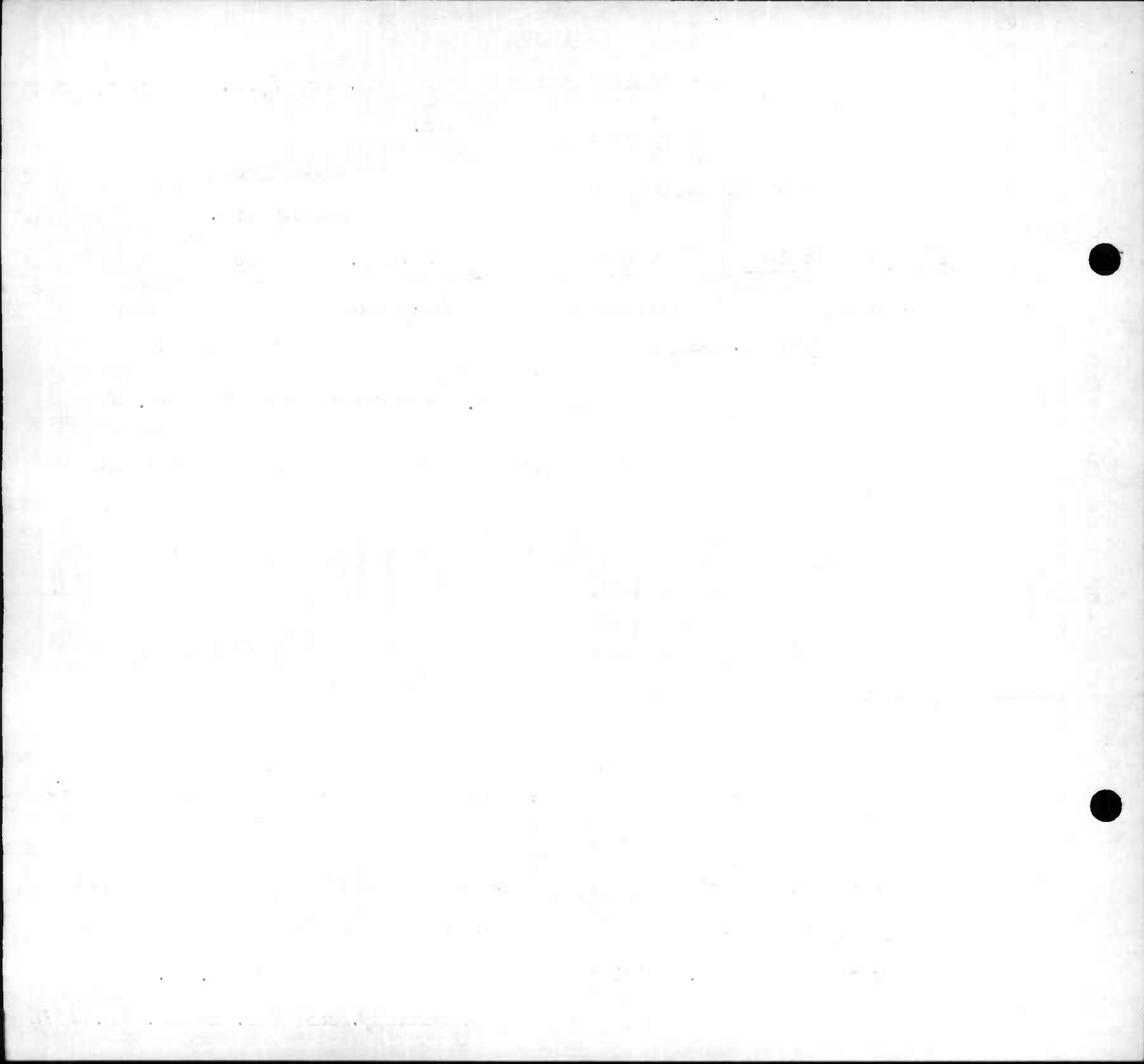
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Handwritten text, possibly a signature or name, located in the lower right section of the page.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

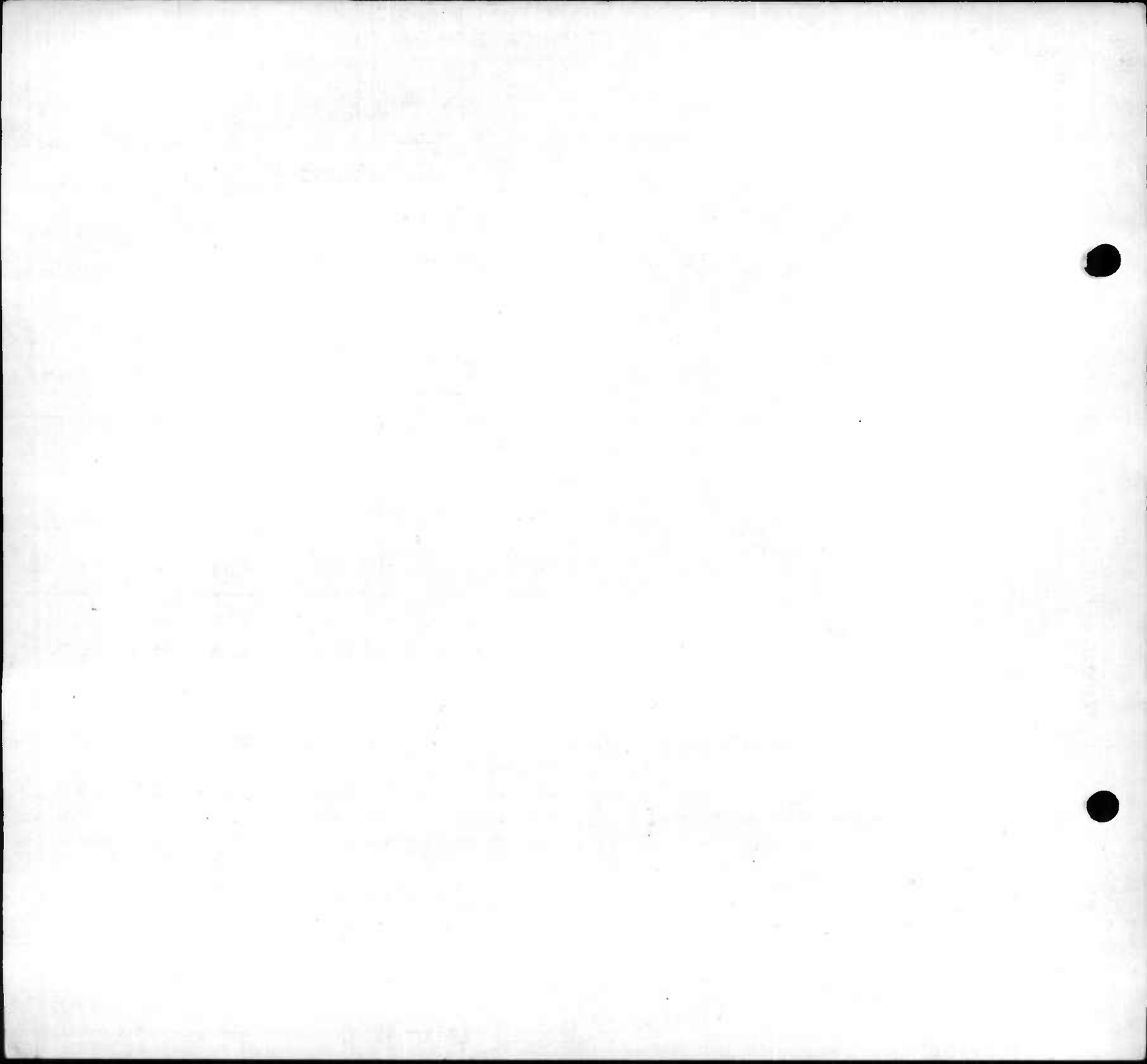
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00644	
BIRTH NO. 66 00644				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Mary Elizabeth Ringrose</i>			2. DATE AND HOUR OF DEATH <i>Jan. 16, 1966. 7:30 p. M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Ashburton Nursing Home</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>26-02</i>		
5. SEX <i>Female</i> 6. RACE <i>White</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow</i>			8. DATE OF BIRTH <i>May 31, 1879.</i> 9. AGE (In years last birthday) <i>86</i>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		
10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>John L. Berger</i>			14. MOTHER'S MAIDEN NAME <i>Elizabeth ?</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>None</i>		
17. INFORMANT ADDRESS <i>Mr. Peter Albert 4751 Ellison Ave. #6</i>					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Arteriosclerotic heart disease</i>			INTERVAL BETWEEN ONSET AND DEATH <i>unknown</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>July 21, 1964</i> to <i>Jan. 16, 1966</i> , that (I) (we) last saw the deceased alive on <i>Jan. 15, 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Abraham B. Hurwitz</i>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>Jan. 17, 1966</i>
23C. PHYSICIAN'S NAME (Type) <i>ABRAHAM B. HURWITZ</i>			23D. ADDRESS M.D. <i>7501 Liberty Road, Baltimore, Md.</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/19/66.</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore Cemetery</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 20 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Felt</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Leonard J. Ruck Inc. Balto. Md. 21214</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. 66 00615	
BIRTH NO. 66 00615		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) BERTHA PARHAM			2. DATE AND HOUR OF DEATH 1-14-66 10:15 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital			A. STATE Maryland		
(If not in hospital or institution, give street address or location)			B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21214		
			D. STREET ADDRESS (If rural, give location) 1424 N. Broadway		
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1-29-33	9. AGE (In years last birthday) 32	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Md.	
13. FATHER'S NAME William Henderson			14. MOTHER'S MAIDEN NAME Irene Harrison		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Emmett Parham 1424 N. Broadway	
18. 540.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) STRESS ULCER DUE TO (B) PERITONITIS DUE TO (C) PERFORATED PYLORIC ULCER			INTERVAL BETWEEN ONSET AND DEATH 10 DAYS 21 DAYS 22 + DAYS		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. MULTIPLE CARDIAC ARRESTS					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-23 1965 to 1-14 1966 , that (I) (we) last saw the deceased alive on 1-14 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James L. Phillips M.D.				23B. DATE SIGNED 1-14-66	
23C. PHYSICIAN'S NAME (Type) James L. Phillips				23D. ADDRESS M.D. The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/19/66		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Westport, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 20 1966			
25B. NAME OF REGISTRAR Rebecca E. Egan		25C. FUNERAL DIRECTOR Milton E. Elickson 11297 Custard			



1
K-523

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ETHEL KNIGHT

2. DATE AND HOUR PRONOUNCED DEAD

14 January 1966 3:40 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

911 N. Durham St.

5. SEX

female

6. RACE

negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

Feb 9, 1928

9. AGE (In years last birthday)

37

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Littleton N. C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Major Boyd

14. MOTHER'S MAIDEN NAME

Katie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Haywood Knight 911 N. Durham St

18.

431X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive heart failure
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Idiopathic myocardial hypertrophy
DUE TO

(C)

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/15/66

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

1/18/66

23C. NAME of CEMETERY or CREMATORY

Mt Auburn Cem.

23D. LOCATION

(City, town, or county)

(State)

Westport Md

24A. DATE REC'D BY HEALTH DEPT

JAN 20 1966

24B. NAME OF REGISTRAR

Robert E. Fink

24C. FUNERAL DIRECTOR

Wilton E. Collicott 1129 N. Charles St

ADDRESS

VALLEY OF THE GODS

THE CONTENT

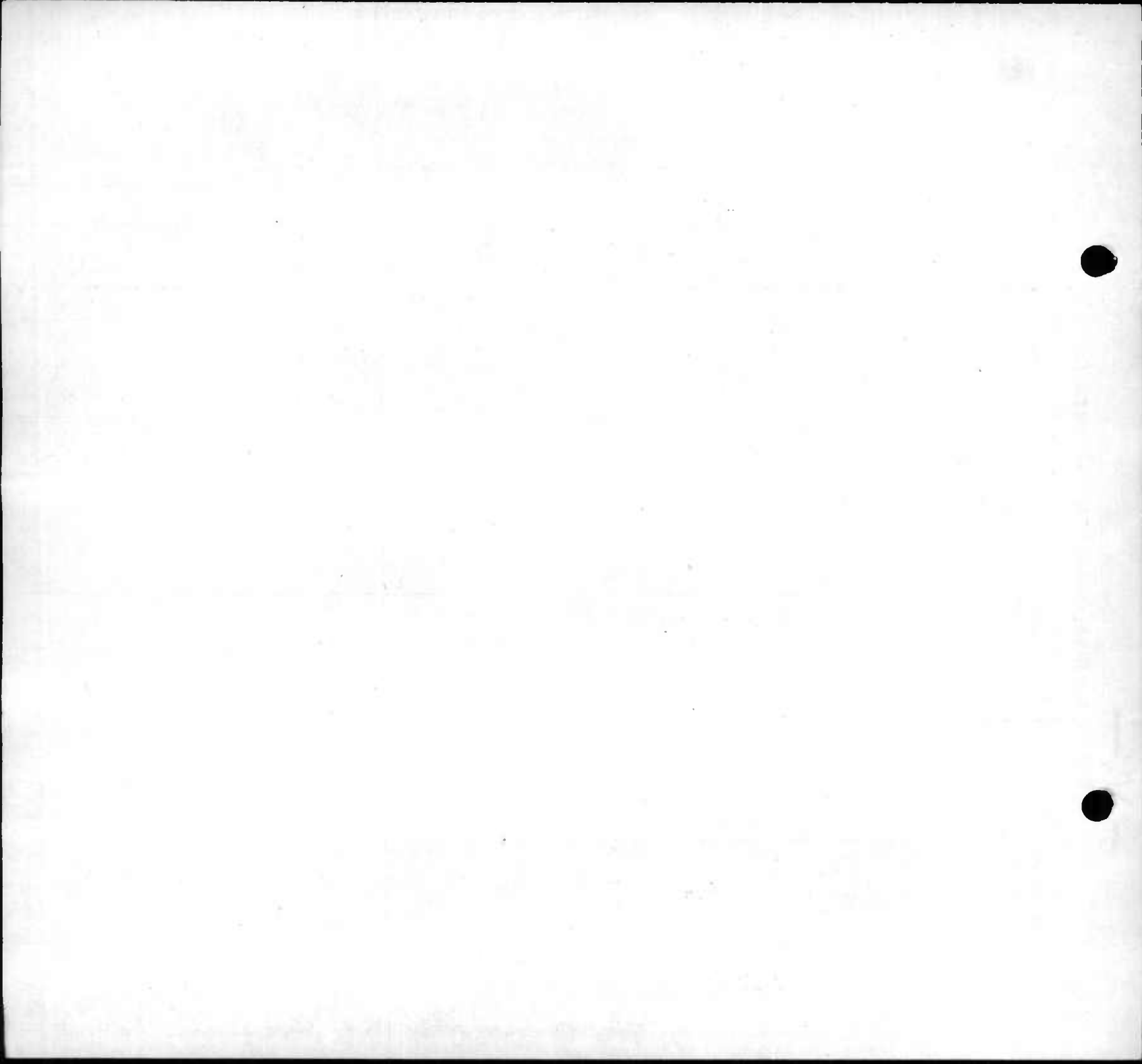
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 66 00647	
BIRTH NO. 66 00647		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Estella Byers</i>		2. DATE AND HOUR OF DEATH <i>January 17, 1966 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>1013 N. Wolfe St.</i>				A. STATE <i>md.</i> B. COUNTY <i>7-04</i>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
				D. STREET ADDRESS (If rural, give location) <i>1013 N. Wolfe St.</i>			
5. SEX <i>Female</i>	6. RACE <i>Colored</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>Nov. 23, 1886</i>	9. AGE (In years last birthday) <i>79</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Abram Proctor</i>			14. MOTHER'S MAIDEN NAME <i>Estella Jackson</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Clara Dixon 939 Wilt Court</i>		
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) <i>Coronary Thrombosis</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i>	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)				(B) <i>Relapsed Coronary Thrombosis</i> DUE TO			
				(C) <i>Myocardial Infarction</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Coronary Atherosclerotic Disease</i>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>11/13/66</i> 19 to <i>1/16/66</i> 19 that (I) (we) last saw the deceased alive on <i>1/13</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Albert L. LaForest</i> M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>1/17/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>DR ALBERT L. LAFOREST</i>				23D. ADDRESS <i>822 N. Bond St</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/20/66</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt. Calvary Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>C.A. County Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 20 1966</i>		25B. NAME OF REGISTRAR <i>Robert S. Johnson</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Walter E. Flicker 1129 N. Caroline St</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <u>66 00618</u>				
BIRTH NO. <u>66 00618</u>		M.E. CASE NO.			2. DATE AND HOUR OF DEATH <u>Jan 16 1966 3:10 P.M.</u>				
1. NAME OF DECEASED (Type or Print) <u>Everett J. Connellee</u>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>35 Church Home & Hospital</u>					A. STATE <u>Maryland</u> B. COUNTY <u>Cecil</u>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Elkton</u> <u>57-00</u>				
D. STREET ADDRESS (If rural, give location) <u>Hermitage Dr.</u>									
5. SEX <u>M</u>	6. RACE <u>Cau</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>married</u>			8. DATE OF BIRTH <u>Sept 20, 1914</u>	9. AGE (In years last birthday) <u>51</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during last 10 years or life even if retired) <u>Business Manufacturing</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Executive Bishop Transport Prod.</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Connellee</u>					14. MOTHER'S MAIDEN NAME <u>Elsie Green</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. RUTH R. CONNELLEE</u>			ADDRESS <u>ELKTON, MD</u>	
18. <u>163X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <u>pneumonia</u>					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>12-22-65</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Carcinoma of Lung</u>			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12-16</u> 19 <u>65</u> to <u>1-16</u> 19 <u>66</u> , that (I) <u>we</u> lost saw the deceased alive on <u>1-16</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> <u>did</u> (did not) view the body after death.									
23A. SIGNATURE <u>José S. Maisog</u> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>1-16-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>José S. Maisog</u>					23D. ADDRESS <u>Church Home & Hospital</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-19-66</u>		24C. NAME OF CEMETERY OR CREMATORY <u>BAKER CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>ABERDEEN MD</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1966</u>			25B. NAME OF REGISTRAR <u>Robert Paul</u>			25C. FUNERAL DIRECTOR <u>PIPPIN FUNERAL HOME</u>			
ADDRESS <u>254 E. MAIN ST. ELKTON, MD.</u>									

For the year

Massachusetts

Elkton

Elkton House & Hospital

Massachusetts

Sept 30, 1911

Massachusetts

Can

17

Manufacturing Dept. Transport and

Elkton Green

William Connelley

Massachusetts

12-33-12 Commission of

2-16-12

1-10

John A. Thompson

John A. Thompson

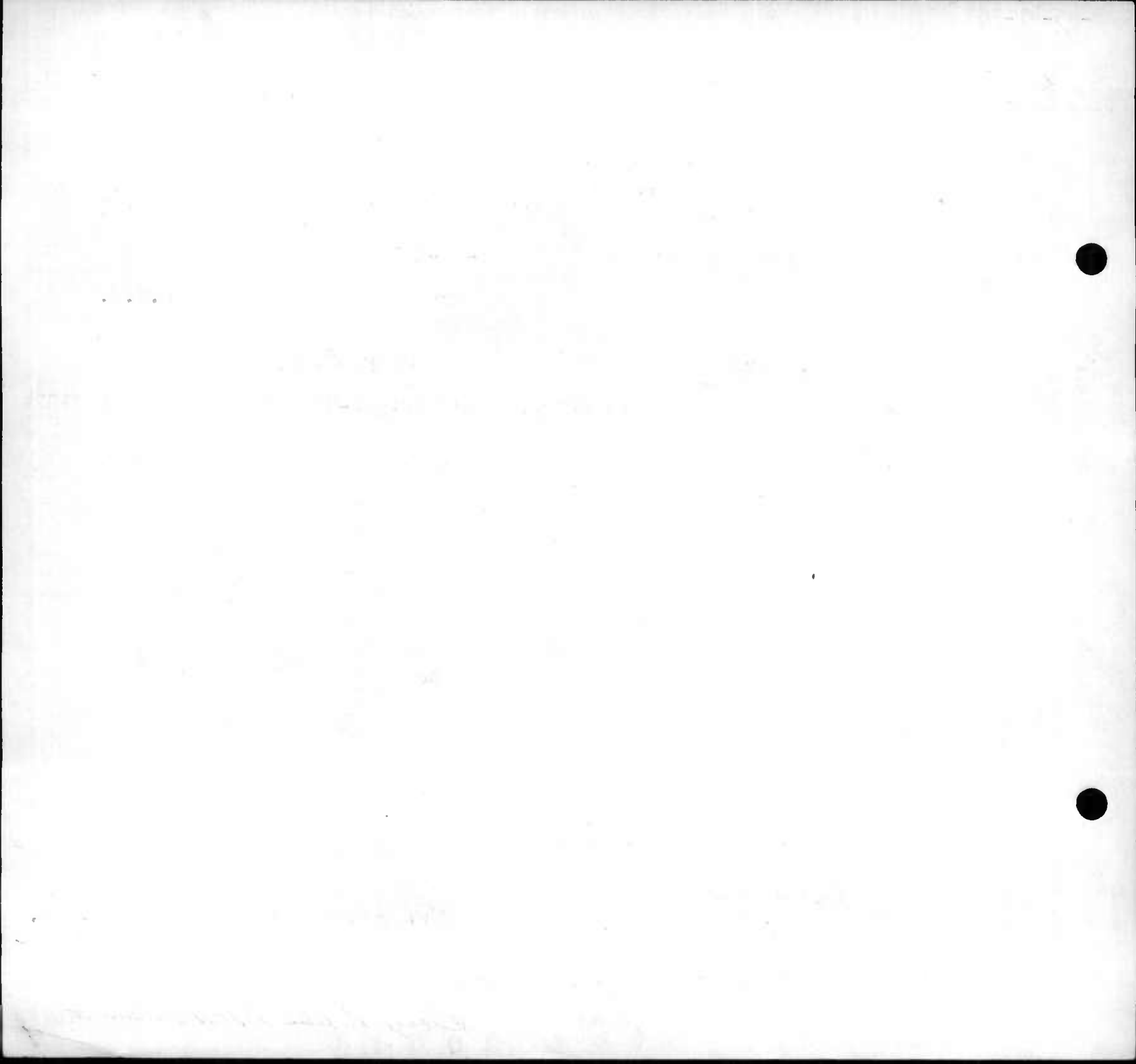
John A. Thompson

SAB-45-41-34
C-632

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00619	
BIRTH NO. 66 00619		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Paul B. Curtis	
2. DATE AND HOUR OF DEATH 1-18-66 11050 P M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 15-47 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2824 Clifton Avenue 21216			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4-17-1912	9. AGE (In years last birthday) 53	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Arthur			14. MOTHER'S MAIDEN NAME Mary Ellis		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 316-07-9292		17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO pneumonia 24 hr (B) DUE TO hyperkalemia - months (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-12-66 to 1-18-66 that (I) (we) last saw the deceased alive on 1-18-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bruce Lee Evatt M.D.				23B. DATE SIGNED 1-18-66	
23C. PHYSICIAN'S NAME (Type) BRUCE LEE EVATT M.D.				23D. ADDRESS 4940 Eastern Avenue, Baltimore, Md. Baltimore City Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-23-66		24C. NAME OF CEMETERY or CREMATORY Carver Mem. Pk. Md.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. JAN 20 1966			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR George A. Lila 1348 N. Calhoun St.			



1
5-363

66 00650

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 00650

BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) JOSEPH STREAT		2. DATE AND HOUR PRONOUNCED DEAD January 18, 1966 4:37 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 305 N. Monastery Ave.	
5. SEX male	6. RACE negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 4-21-1905
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 60
11. BIRTHPLACE (State or foreign country) Va		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Charlie Streat		14. MOTHER'S MAIDEN NAME Pinky Scott	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT Audrey Streat
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 432.1 I Arteriosclerotic cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Rudiger Breitenecker, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Rudiger Breitenecker, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-19-66			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 1-22-66	
23C. NAME of CEMETERY or CREMATORY Antietam Cmt		23D. LOCATION (City, town, or county) (State) Balto Md	
24A. DATE REC'D BY HEALTH DEPT. JAN 20 1966		24B. NAME OF REGISTRAR Robert E. Felt	
24C. FUNERAL DIRECTOR Choy Wilson		24D. ADDRESS 100 N. ...	

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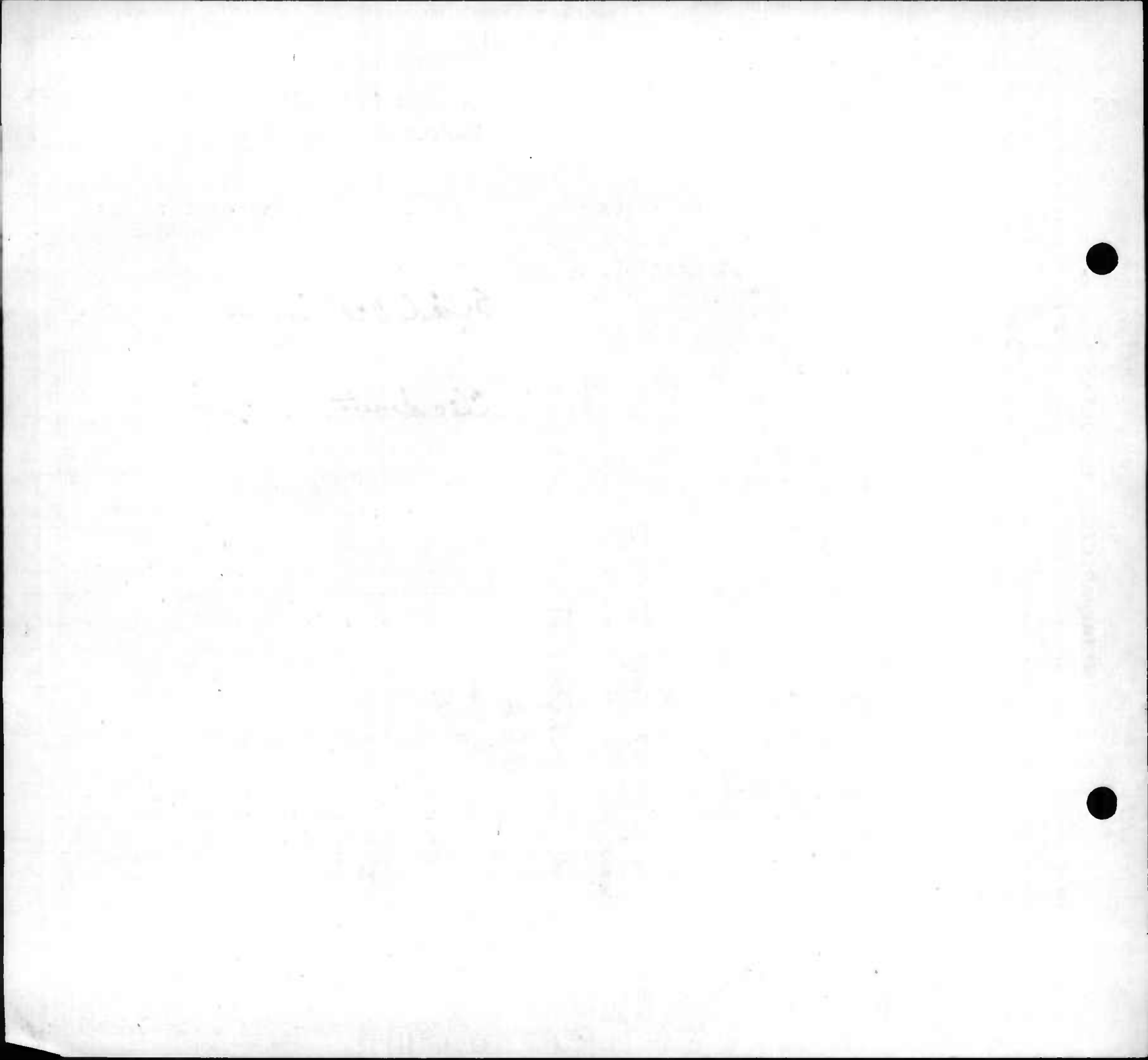
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00651	
BIRTH NO. 66 00651		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Edward Smith			
2. DATE AND HOUR OF DEATH 1/19/66 8:00 A.M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
THE JOHNS HOPKINS HOSPITAL		A. STATE MARYLAND			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 1504 EAST MONUMENT STREET			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5-2-13	9. AGE (In years last birthday) 52	10. Under 1 Yr. Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Enfield North Carolina	
13. FATHER'S NAME EDWARD SMITH		14. MOTHER'S MAIDEN NAME ALICE ARRINGTON		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Cleo Smith	
18. 290.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO Hypotension + Pulmonary Edema + Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH 3 hrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Megaloblastic Anemia		3 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/6 1966 to 1/19 1966, that (I) (we) last saw the deceased alive on 1/19 1966 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. Eugene Page		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/19/66	
23C. PHYSICIAN'S NAME (Type) E. Eugene Page		23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-23-66		24C. NAME OF CEMETERY or CREMATORY New Cemetery	
24D. LOCATION (City, town, or county) North Carolina		(State) North Carolina			
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1966		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Thomas A. Field	
				ADDRESS Enfield North Carolina	



66 00652

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 00652

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

LEONORA HARRIS

2. DATE AND HOUR PRONOUNCED DEAD

January 18, 1966 10:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

915 Pierce St.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

915 Pierce St.

5. SEX

female

6. RACE

negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

April 3-1914

9. AGE (In years
last birthday)

51

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Wilson North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Martha Weston 224 Pierce St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)(A) Fatty metamorphosis of the liver
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-19-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1-22-66

23C. NAME of CEMETERY or CREMATORY

Mt Auburn Cem

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JAN 20 1966

Chas. G. Wilson

Chas. G. Wilson

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little girl
and my
little girl

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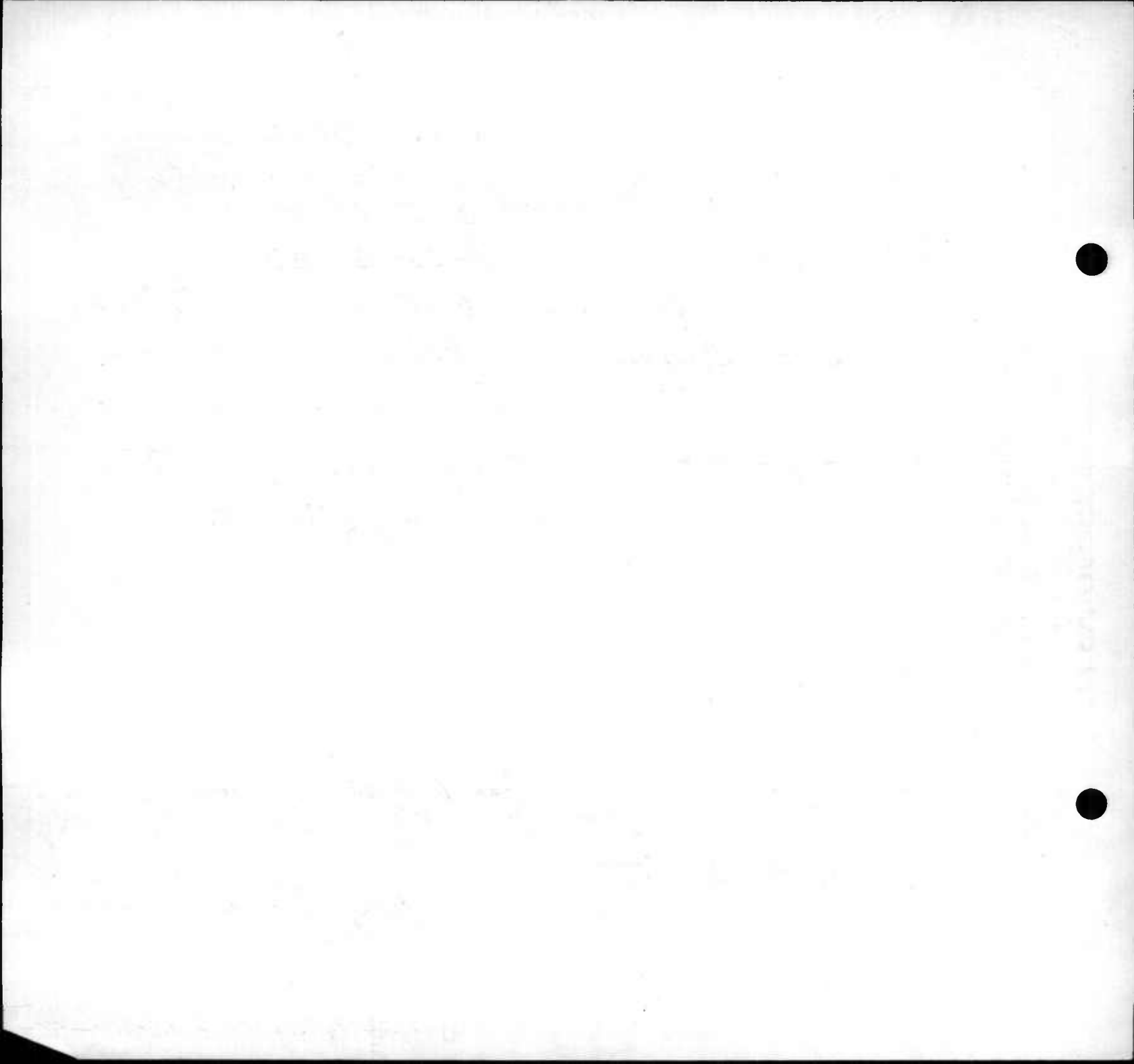
my

my little girl

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 10		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00653	
M.E. CASE NO. 66 00653		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) REV. EDWARD GRIFFIN			2. DATE AND HOUR OF DEATH 19 JAN 1966 10:55 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hosp. Baltimore, Maryland			A. STATE W. VA. B. COUNTY South Charleston		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) South Charleston V-45		
			D. STREET ADDRESS (If rural, give location) 305 E 8th St.		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 1-26-15	9. AGE (In years last birthday) 50	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Priest		10B. KIND OF BUSINESS OR INDUSTRY Religious	11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James F. Griffin			14. MOTHER'S MAIDEN NAME Bridget Kennedy		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Records, Bon Secours Hosp		
18. 5-40-11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Paralytic ulcer			INTERVAL BETWEEN ONSET AND DEATH Days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Acute Necrotizing Pancreatitis		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 11 Jan 66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED perforated ulcer		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 6 1966 to Jan 19 1966 , that (I) (we) last saw the deceased alive on Jan 19 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. M. Hippolito			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 19 Jan 66
23C. PHYSICIAN'S NAME (Type) J. M. Hippolito			23D. ADDRESS Bon Secours Hosp. Baltimore, Maryland		
24A. BURIAL CREMATION, DATE REMOVAL (Specify) Burial Jan 21/66		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) Weston W. Va.	
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1966		25B. NAME OF REGISTRAR Robert E. Smith		25C. FUNERAL DIRECTOR ADDRESS W. H. 4101 E. Edmondson Ave	



K-620

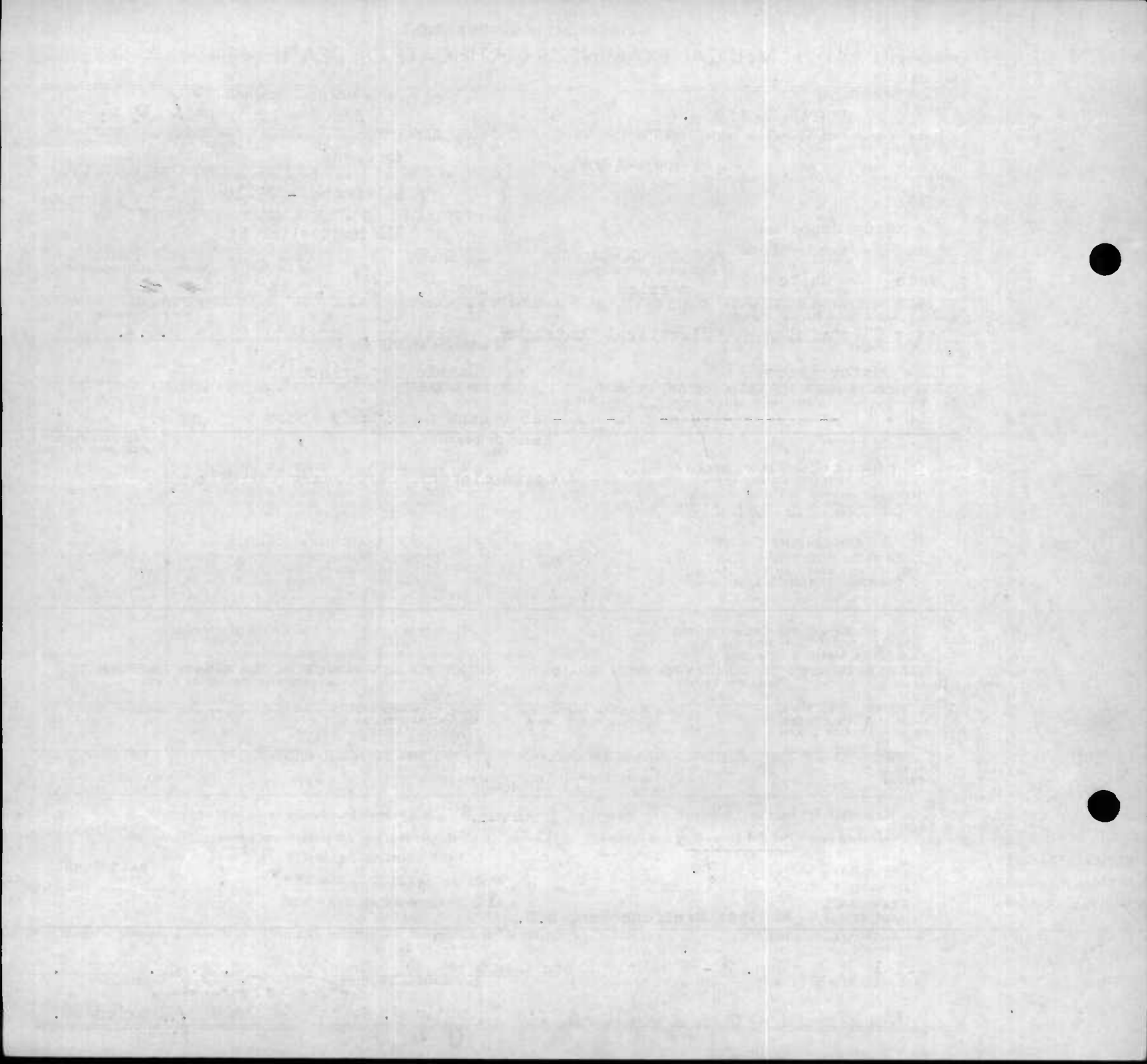
BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 66 00654 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 00654

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) GUSTAV KOORS (W.)			2. DATE AND HOUR PRONOUNCED DEAD January 19, 1966 ¹¹P. 8:05 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore - 21218 9-04 D. STREET ADDRESS (If rural, give location) 915 Montpelier St.		
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH June 27, 1906	9. AGE (In years last birthday) 59	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Master Electrician		10B. KIND OF BUSINESS OR INDUSTRY Electrical Contractor		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Gustav Koors			14. MOTHER'S MAIDEN NAME Jennie May Driscoll		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 01-2712-215		17. INFORMANT Edna E. Ritchie Koors	
			ADDRESS (same)		

MEDICAL CERTIFICATION	18. CAUSE OF DEATH 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Arteriosclerotic cardiovascular disease (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) DUE TO (A)..... (B)..... (C)..... INTERVAL BETWEEN ONSET AND DEATH				
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
	19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
	21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
	21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
	22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breiteneker, M.D. DATE SIGNED 1-19-66				
	23A. BURIAL CREMATION, REMOVAL (Specify) Burial	23B. DATE Sat. Jan. 22-66	23C. NAME OF CEMETERY or CREMATORY Holy Cross Cemetery	23D. LOCATION (City, town, or county) (State) Brooklyn A. A. Co. Md.	
	24A. DATE REC'D BY HEALTH DEPT. JAN 20 1966		24B. NAME OF REGISTRAR 202-68-7400	24C. FUNERAL DIRECTOR ADDRESS Curtis E. Evans 1400 S. Charles St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

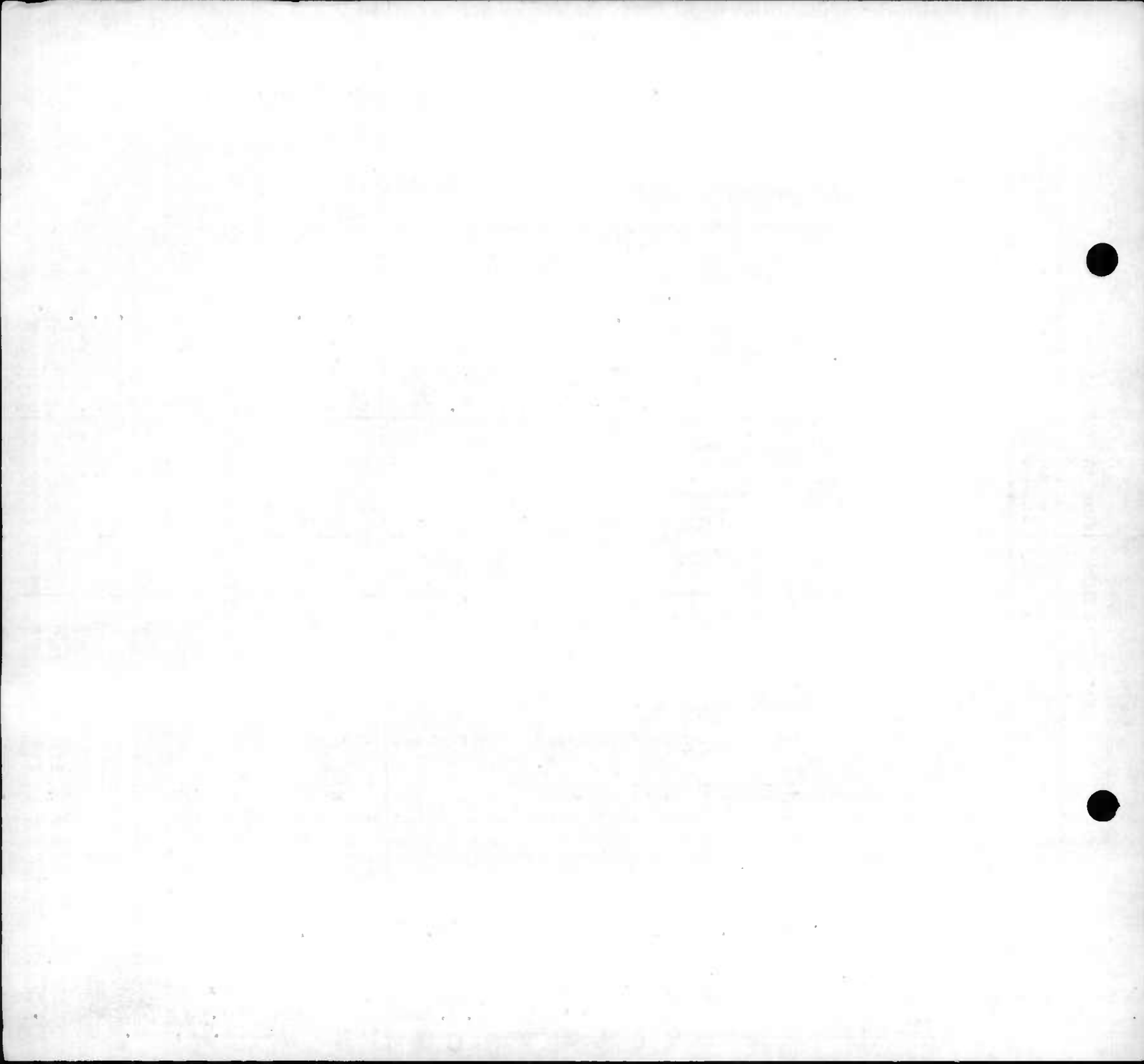
BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH											
BIRTH NO.		Registered No. 66 00655									
M.E. CASE NO.		66 00655									
1. NAME OF DECEASED (Type or Print)						2. DATE AND HOUR OF DEATH					
MATRICCIANI, ROSE S.						1-18-66 4:45 P M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)						A. STATE B. COUNTY					
ST AGNES HOSPITAL						MARYLAND					
						C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
						GLEN BURNIE					
						D. STREET ADDRESS (If rural, give location)					
						7633 NINTH COURT					
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. Under 1 Yr. Months Days Hours Min.	
FEMALE		WHITE		MARRIED		5-18-18		47			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		
HOUSEWIFE									PENNSYLVANIA		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
ANTHONY SOLOMON						RACHEL KALEAL					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
NO						130180401			CATON AVES. 21229		
						ST AGNES HOSPITAL RECORDS, WILKINS AND					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH						CAUSE OF DEATH					
(This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.)						(A) DUE TO					
						Septic shock					
19. ANTECEDENT CAUSES						(B) DUE TO					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						Peritonitis with Paralytic Ileus					
						(C) DUE TO					
II						INTERVAL BETWEEN ONSET AND DEATH					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		(Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 1-9-19 66 to 1-18-19 66, that (I) (we) last saw the deceased alive on 1-18-19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE								23B. DATE SIGNED			
Benjamin C. Guzman M.D.								1-18-66			
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS					
BENJAMIN C. GUZMAN						ST. AGNES HOSPITAL WILKINS AND CATON					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
Burial		Jan. 22/66		Holy Cross Cem.				6020 Gov. Richie Hwy.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR ADDRESS			
JAN 20 1966				R. E. Guzman				Frank E. Hove 322 S. High St.			

see letter in file - Bureau of Biological
American Red Cross

James H. H. H. H.

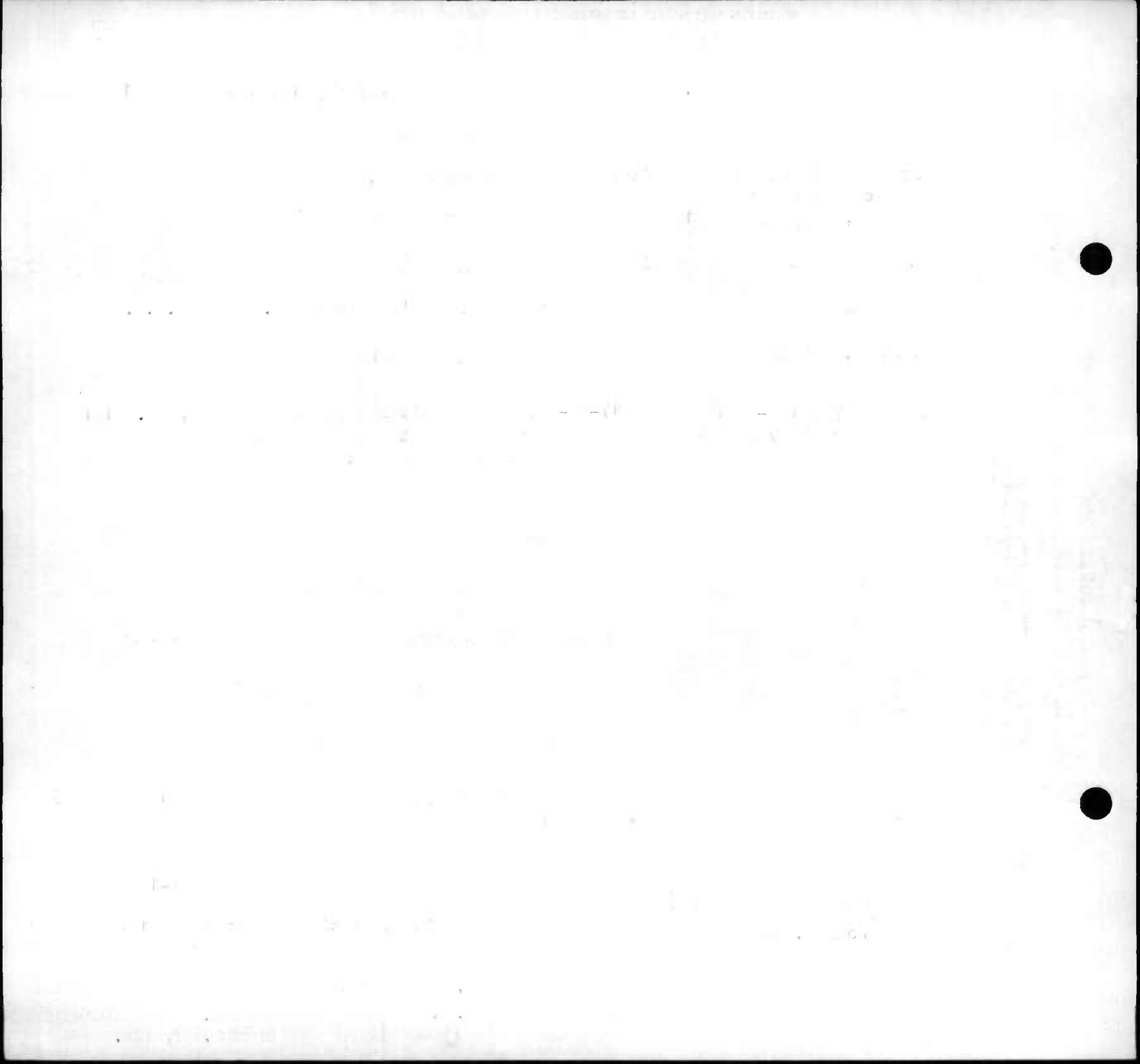
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 00656</u>	
BIRTH NO. <u>66 00656</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Priscilla C. Bouton</u>		2. DATE AND HOUR OF DEATH <u>January 18, 1966</u> <u>10:00 P. M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>27-48</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>626 Tunbridge Road</u>		D. STREET ADDRESS (If rural, give location) <u>626 Tunbridge Road</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Never Married</u>	8. DATE OF BIRTH <u>11/14/1907</u>	9. AGE (In years last birthday) <u>58</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Md. State Nurses Assoc.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
13. FATHER'S NAME <u>Walter S. Bouton</u>		14. MOTHER'S MAIDEN NAME <u>Florence R. White</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-26-4031</u>		17. INFORMANT ADDRESS <u>Mrs. Beatrice Barrett, Georgetown, Maine</u>	
18. <u>420.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Malignant Hypertension one year</u> <u>Coronary thrombosis 1 day</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>		CAUSE OF DEATH (A) <u>Malignant Hypertension</u> DUE TO (B) <u>Coronary thrombosis</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>one year</u> <u>1 day</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>July 1961</u> to <u>Jan 18 1966</u> , that (I) (we) last saw the deceased alive on <u>Dec 10 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ralph G. Hills</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>Jan 20 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>Ralph G. Hills</u>		23D. ADDRESS M.D. <u>18 E. Eager St.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>1/21/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Greenmount</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1966</u>			
25B. NAME OF REGISTRAR <u>H.W. Jenkins & Sons Co.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>4905 York Rd. Balto. 12, Md.</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. <u>66 00657</u>	
BIRTH NO. <u>66 00657</u>					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>HARRIS, BERNARD AUBREY</u>		2. DATE AND HOUR OF DEATH <u>January 19, 1966</u> <u>1:45 P</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Veterans Administration Hospital</u> <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u>		A. STATE <u>Maryland</u> B. COUNTY <u>27-12</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore,</u>			
		D. STREET ADDRESS (If rural, give location) <u>416 Evesham Avenue</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>3/28/97</u>	9. AGE (In years last birthday) <u>68</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Banker-Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Stocks & Bonds</u>		11. BIRTHPLACE (State or foreign country) <u>St Mary's County, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>John H. Harris</u>		14. MOTHER'S MAIDEN NAME <u>Mary Readmond</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>7/8/18 - 2/12/19</u>		16. SOCIAL SECURITY NO. <u>217-12-5173</u>		17. INFORMANT ADDRESS <u>VA Hospital Records Baltimore, Md. 21218</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>420.14-162.1</u> <u>Coronary Heart Disease With Myocardial Infarct</u>		CAUSE OF DEATH <u>Coronary Heart Disease With Myocardial Infarct</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 Years</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Bronchogenic Carcinoma</u>				1 Year	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <u>October 25th</u> 19 <u>66</u> to <u>January 19th</u> 19 <u>66</u> , that (X) (we) last saw the deceased alive on <u>January 19th</u> 19 <u>66</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John S. Howe</u> M.D.		23B. DATE SIGNED <u>1-19-66</u>		23C. PHYSICIAN'S NAME (Type) <u>John S. Howe</u>	
23D. ADDRESS <u>VA Hospital, Baltimore, Maryland 21218</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/22/1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>Maryland</u>		25A. DATE RECORDED BY HEALTH DEPT. <u>JAN 20 1966</u>			
25B. NAME OF REGISTRAR <u>Robert C. Jenkins</u>		25C. FUNERAL DIRECTOR ADDRESS <u>H.W. Jenkins & Sons Co. 4905 York Road</u> <u>Balto. 12, Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 00658	
BIRTH NO. 66 00658							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) William L. Cullum				2. DATE AND HOUR OF DEATH Jan 18, 1966 11:20 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 35 Church Home Hospital		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 3-81	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore City			
				D. STREET ADDRESS (If rural, give location) 311 Ballou Crt.			
5. SEX M	6. RACE Cau	7. MARRIED (Indicate by check) <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced	8. DATE OF BIRTH 6-11-1899	9. AGE (In years lost day) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Painter &		10B. KIND OF BUSINESS OR INDUSTRY Decorator		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lee J. Cullum				14. MOTHER'S MAIDEN NAME Rosie M Moore			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 219-0341608		17. INFORMANT ADDRESS Theresa Rybak 136 S Patterson Ph Baltimore			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 422.141.260 X				(A) Arteriosclerotic Cardio-vascular Disease &		14 yrs	
ANTECEDENT CAUSES				(B) DUE TO Myocardial Degeneration			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Diabetes Mellitus			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from Jan 10 19 66 to Jan 18 19 66 , that the lost saw the deceased alive on Jan 18 19 66 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (We) <input checked="" type="checkbox"/> (did not) view the body after death.							
23A. SIGNATURE Jose S. Masios M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-18-66	
23C. PHYSICIAN'S NAME (Type) Jose S. Masios M.D.				23D. ADDRESS Church Home Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/20/1966		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1966		25B. NAME OF REGISTRAR R. J. ...		25C. FUNERAL DIRECTOR ADDRESS Wynk ... + sons Baltimore, Md.			

Dr. Thomas
311 B. Hall
8-11-88

C. R. House Hospital
M. C. C.

M. C. C.
R. C. C.
Theresa R. C. C.

L. C. C.

Ante-natal
Gynaecological
Department

Dr. R. C. C.

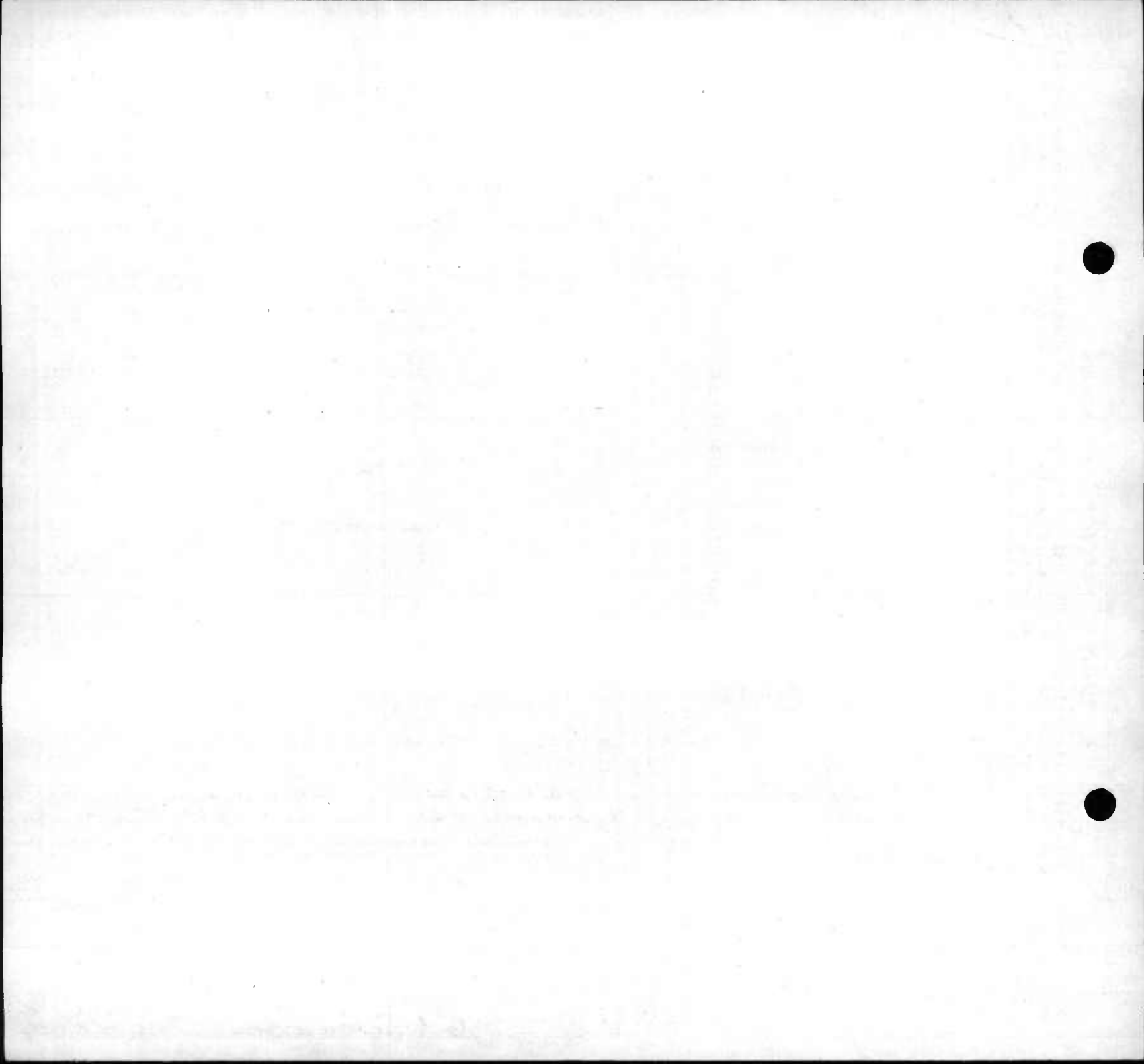
1-18-88
C. R. C.

1-18-88
C. R. C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

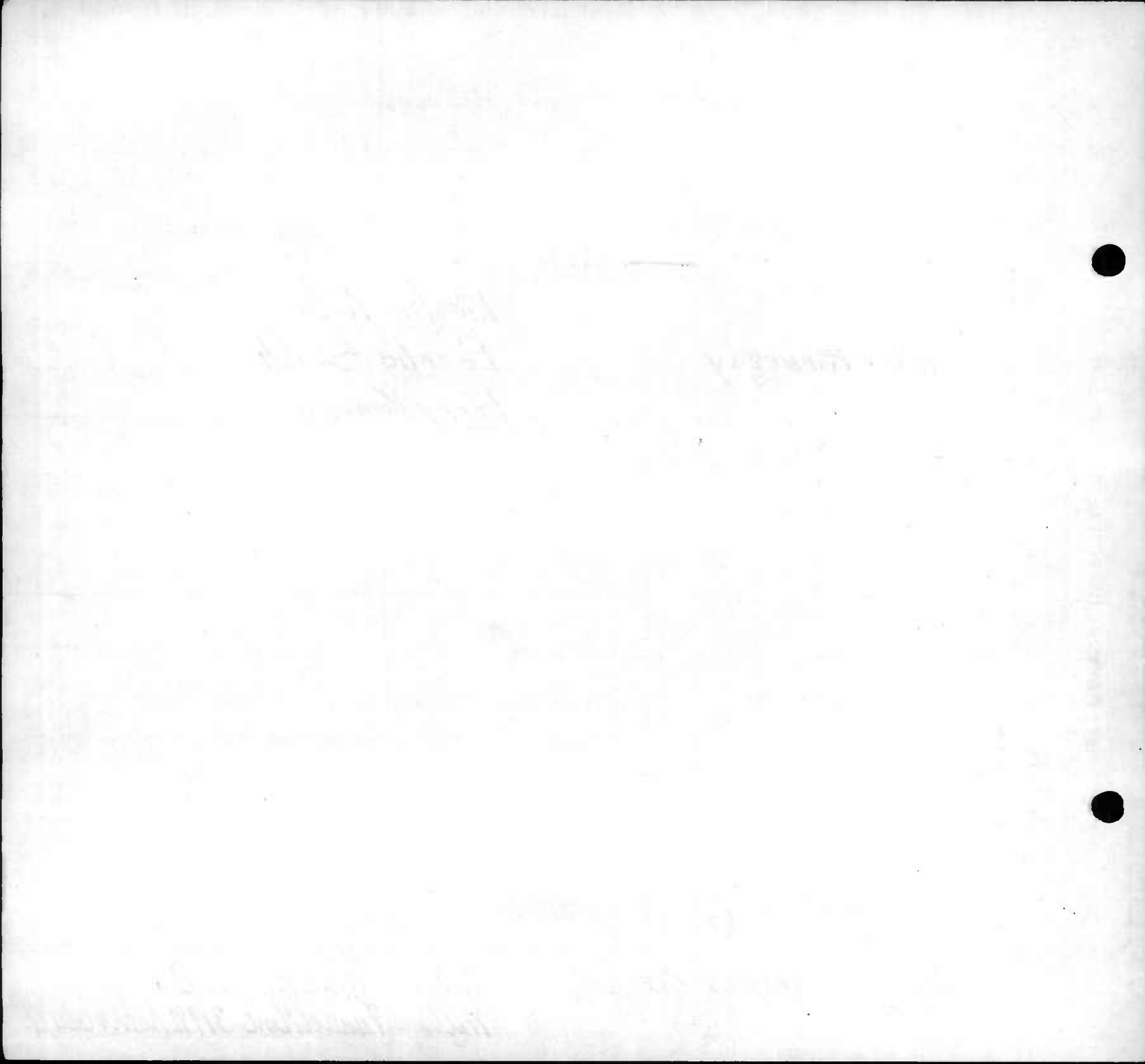
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00659	
BIRTH NO. 66 00659		CERTIFICATE OF DEATH		Registered No. 66 00659	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Bertha L. Vogelsang		2. DATE AND HOUR OF DEATH January 18, 1966 5 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Wesley Home, Inc. 2211 West Rogers Avenue Baltimore, Maryland 21209		D. STREET ADDRESS (If rural, give location) 2211 West Rogers Avenue 21209		E. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Aug. 4, 1890	9. AGE (In years last birthday) 75	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Carroll County, Md.	
13. FATHER'S NAME Albert Gilbert		14. MOTHER'S MAIDEN NAME Margaret Dudderar		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-52-3268		17. INFORMANT ADDRESS The Wesley Home, Inc. same address as above	
18. 422141260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO Ischemic cardio-vascular disease		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus. Parkinson Disease		(C) DUE TO			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 27 November 1962 to 18 January 1966 that (I) (we) last saw the deceased alive on 18 January 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John W Barnaby		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 20 Jan 66	
23C. PHYSICIAN'S NAME (Type) John W Barnaby		23D. ADDRESS M.D. 1531 E North Ave Baltimore Md 21213			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/21/1966		24C. NAME of CEMETERY or CREMATORY Pipe Creek Cemetery	
24D. LOCATION (City, town, or county) Carroll County, Maryland		24E. STATE (State) Maryland		24F. FUNERAL DIRECTOR	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
1966		John P. Fickman + Son		Baltimore, Md. North E. P. Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 00660					CERTIFICATE OF DEATH		Registered No. 66 00660		
M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) Roland Kornegay				
2. DATE AND HOUR OF DEATH 1/19/66 4:32 A.M.					3. PLACE OF DEATH IN BALTIMORE, MARYLAND				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 Lutheran					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 16-08				
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore					D. STREET ADDRESS (If rural, give location) 627-Edgwood St.				
5. SEX Male		6. RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married Single		8. DATE OF BIRTH 1/24/32		9. AGE (In years last birthday) 34	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction worker		10B. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Kingston N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.	
13. FATHER'S NAME Willie Kornegay					14. MOTHER'S MAIDEN NAME Pearlle Smith				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Henry Kornegay		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 600.0 I					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) DUE TO Uremia				
ANTECEDENT CAUSES					(B) DUE TO Chronic Pyelonephritis				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Congestive Heart Failure									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from December 28, 1965 to January 19, 1966, that (I) (we) last saw the deceased alive on January 17, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Robert C. Blackmon M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 1/19/66	
23C. PHYSICIAN'S NAME (Type) Robert C. Blackmon M.D.					23D. ADDRESS Lutheran Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify) Shipped		24B. DATE 1/24/66		24C. NAME OF CEMETERY OR CREMATORY N.C. Kingston N.C.		24D. LOCATION (City, town, or county) (State) Kingston N.C.			
25A. DATE RECD. BY HEALTH DEPT. JAN 20 1966		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Williams Funeral Home		ADDRESS 3192 Schroeder St.			



44-01-10
JJ L-6001

66 00661

BALTIMORE CITY HEALTH DEPARTMENT

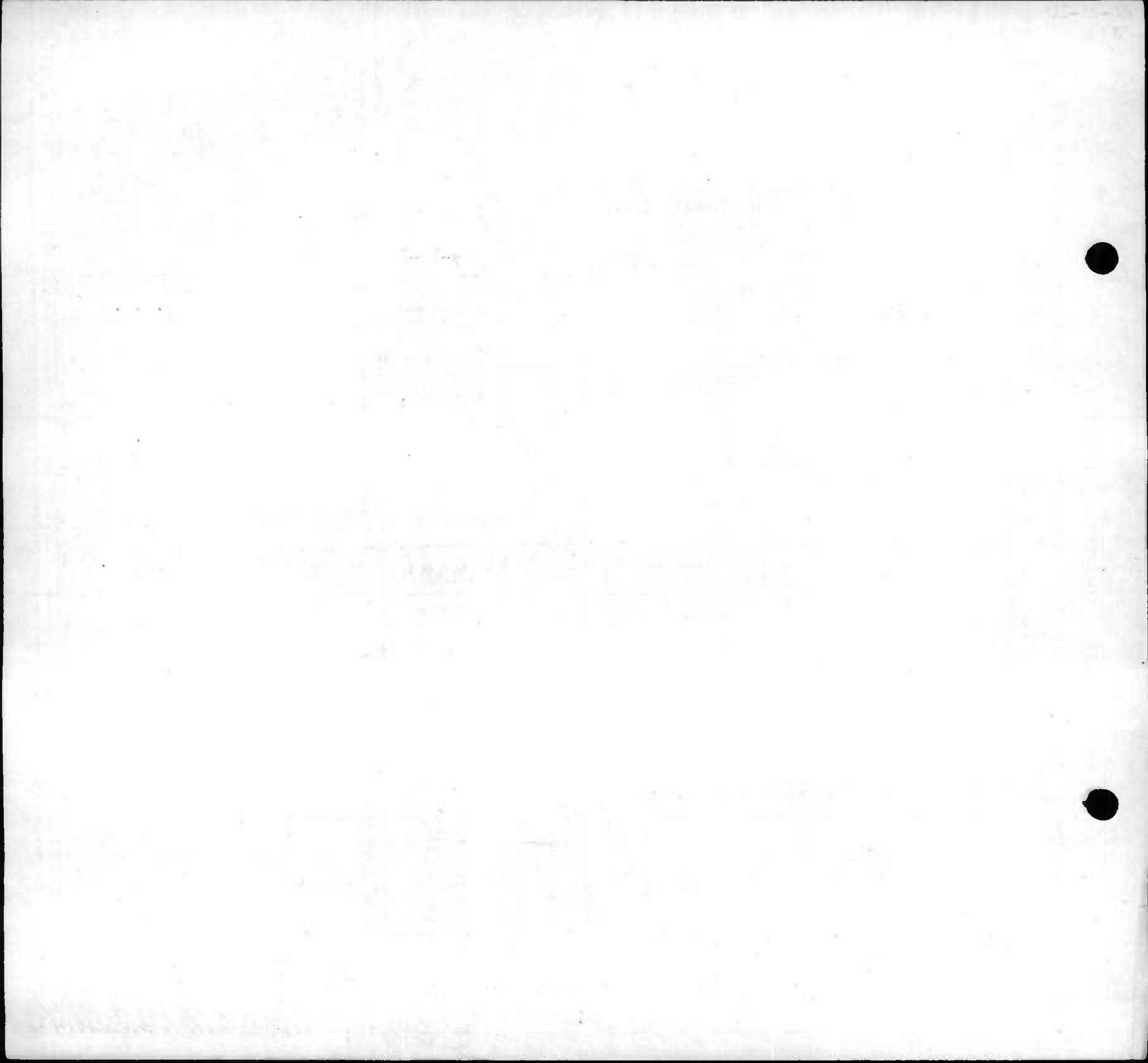
CERTIFICATE OF DEATH

Registered No. 66 00661

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LOWERY, TONA		2. DATE AND HOUR OF DEATH 1.15.66 7.10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospital 4940 EASTERN AVENUE #21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 1104 Sarah Ann St. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1104 SARAH ANN ST.			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SEPARATED		8. DATE OF BIRTH 9-18-12	9. AGE (In years last birthday) 53	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME FRANK CARROLL			
14. MOTHER'S MAIDEN NAME LOLA MASON				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO.				17. INFORMANT RECORDS: BCH 4940 EASTERN AVENUE #21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 150 X I Maunition Carcinoma, Esophagus Generalized metastasis				INTERVAL BETWEEN ONSET AND DEATH 11.6.65 7.10.65 11.6.65			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 17.10.65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca. Esophagus		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11.6.65 to 1.15.66 , that (I) (we) last saw the deceased alive on 1.15.66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Quirico Santiago				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1.15.66	
23C. PHYSICIAN'S NAME (Type) DR. QUIRICO SANTIAGO				23D. ADDRESS M.D. 4940 EASTERN AVENUE #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan 21, 1966		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1966		25B. NAME OF REGISTRAR Re. A. J. ...		25C. FUNERAL DIRECTOR Williams Funeral Home 3497 Schroeder St.			



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

2. DATE AND HOUR PRONOUNCED DEAD

Schofield Bass

1/18/66

8:55 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

321 N. Carrollton Ave.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Feb. 2, 1907

9. AGE (In years
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

E.B. Bass

14. MOTHER'S MAIDEN NAME

Clara Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Carrie McCoy 321 N. Carrollton Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple pulmonary thrombi
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/18/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION (City, town or county) (State)

24A. DATE REC'D BY HEALTH/DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

WALLER POLICE

RESIDENT

WALLER POLICE

WALLER POLICE

WALLER POLICE

WALLER POLICE

WALLER POLICE

WALLER POLICE

WALLER POLICE

WALLER POLICE

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WALLER POLICE

FUNERAL DIRECTOR: IMPORTANT

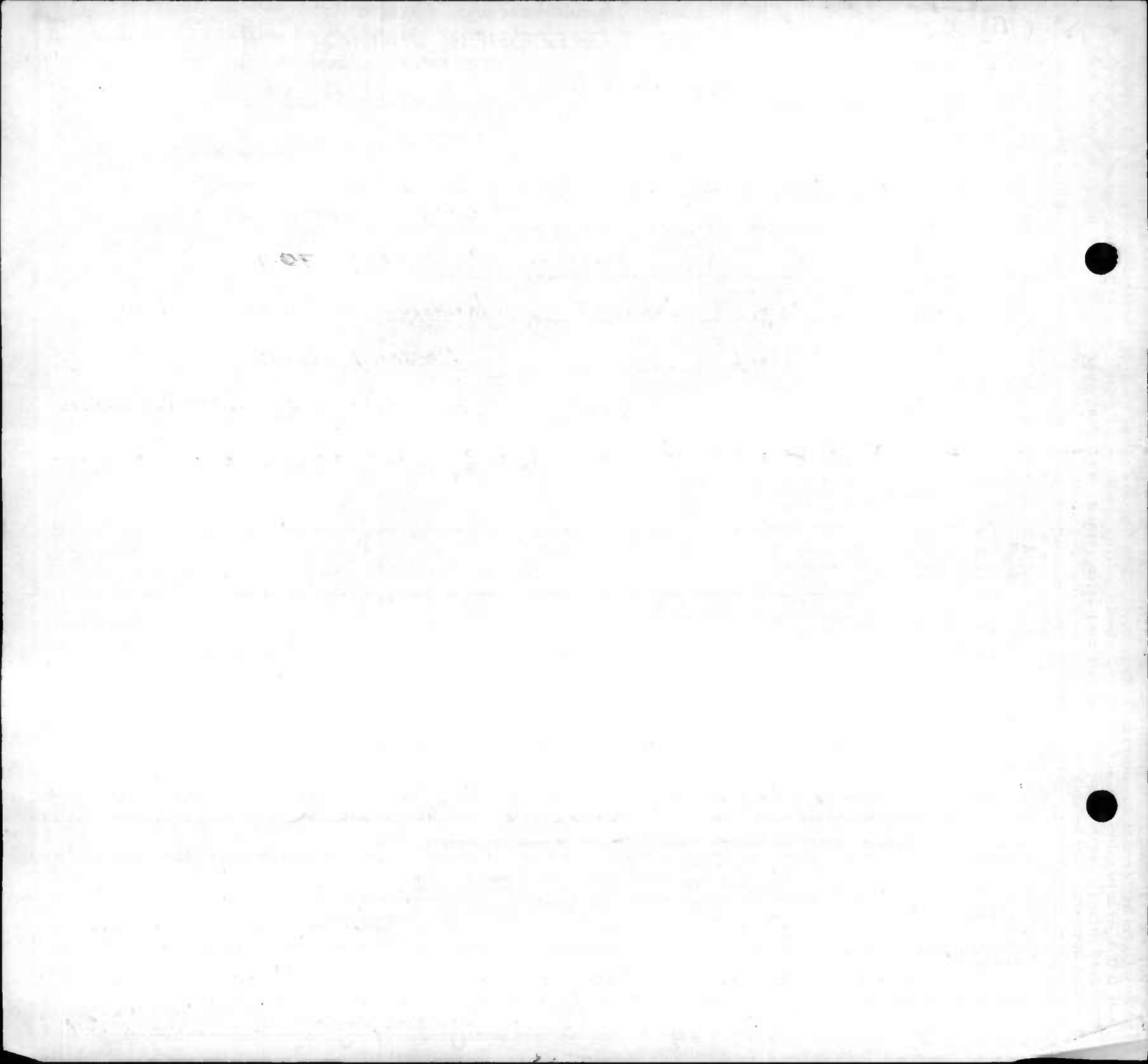
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 00663	
BIRTH NO. M.E. CASE NO.		66 00663					
1. NAME OF DECEASED (Type or Print) Leonard Wheeler				2. DATE AND HOUR OF DEATH Jan 16 1966 8:00 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY Baltimore city	
University Hospital				C. CITY OR TOWN Baltimore		(If outside city limits, write RURAL and give township)	
				D. STREET ADDRESS 326 N. Pine St.		(If rural, give location)	
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married (Sep)		8. DATE OF BIRTH 4/2/17	9. AGE (In years last birthday) 48	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe repairman				10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Junius A. Wheeler				14. MOTHER'S MAIDEN NAME Lillie M. ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 577-18-1466		17. INFORMANT patient (hospital chart)		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 465XV-002.1 pulmonary emboli				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH unknown	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO		(B) DUE TO	
				(C) DUE TO			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. probable tuberculosis							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from 1/14 19 66 to 1/16 19 66, that (H) (we) last saw the deceased alive on 1/16 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Susan L. Howard, MD				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) SUSAN L HOWARD, MD		23D. ADDRESS University Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/20/1966		24C. NAME OF CEMETERY or CREMATORY Bellevue Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1966		25B. NAME OF REGISTRAR C. E. F. Smith		25C. FUNERAL DIRECTOR Williams Funeral Home		ADDRESS 314 N. Pine St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00664	
BIRTH NO. 66 00664		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Sister MARY MAURELIA		2. DATE AND HOUR OF DEATH 1-16-66 1 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION 34 Bon Secours Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 6401 N. CHARLES ST.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 9-30-1894	9. AGE (In years last birthday) 71	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROVINCIAL Sup.		10B. KIND OF BUSINESS OR INDUSTRY CONVENT		11. BIRTHPLACE (State or foreign country) IRVINGTON, New Jersey	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Stahl		14. MOTHER'S MAIDEN NAME MARGARET Seitz	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT CONVENT RECORDS ADDRESS 6401 N. CHARLES	
18. 193.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) GLIOMA, LEFT CEREBRAL HEMISPHERE		CAUSE OF DEATH (A) DUE TO GLIOMA, LEFT CEREBRAL HEMISPHERE		INTERVAL BETWEEN ONSET AND DEATH 5 Months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) yes	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (M) (this hospital) attended the deceased from JAN 8 1966 to JAN 16 1966 , that (N) (we) last saw the deceased alive on JAN 16 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Samuel C. Chvo				23B. DATE SIGNED 1-16-1966	
23C. PHYSICIAN'S NAME (Type) SAMUEL C. Chvo		23D. ADDRESS BON SECOURS Hosp. BALT. MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-19-66		24C. NAME OF CEMETERY or CREMATORY SISTERS CEMETERY	
24D. LOCATION (City, town, or county) (State) NOTCH CLIFF, GEN ARM, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JAN 20 1966			
25B. NAME OF REGISTRAR Raymond V. Curran		25C. FUNERAL DIRECTOR 817 SCARLETT DR. TOWSON, MD. 21204			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

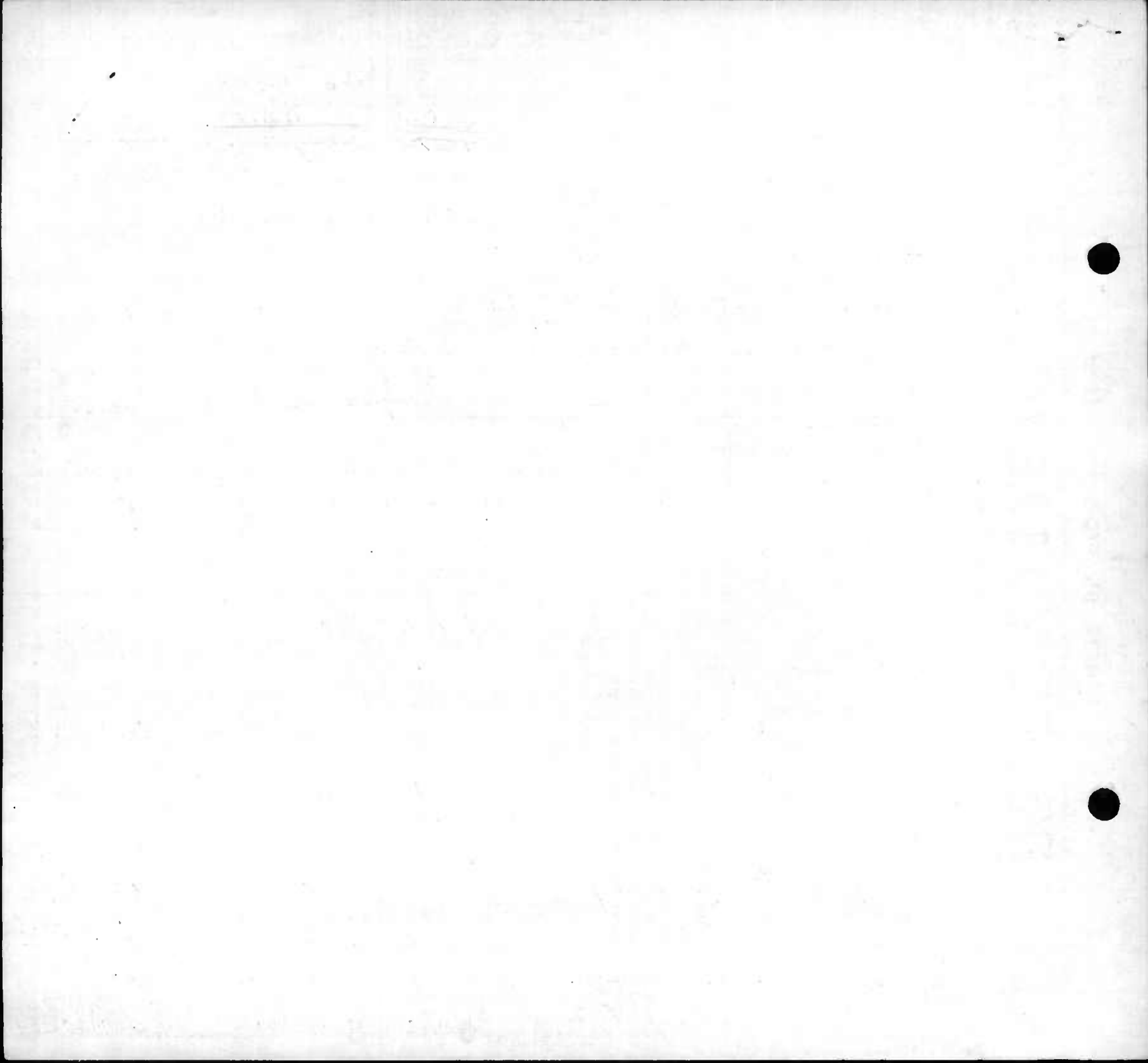
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <u>66 00665</u>				
BIRTH NO. <u>66 00665</u>		M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <u>JASON MC VAY AUSTIN</u>					2. DATE AND HOUR OF DEATH <u>Jan. 17, 1966</u> <u>6: 25 A.M.</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>US Public Health Service Hospital</u> <u>Wyman Pk. Drive & 31st Street</u>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>27-19</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>5705 Bland Avenue</u>				
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widower</u>		8. DATE OF BIRTH <u>5/30/86</u>	9. AGE (In years last birthday) <u>79</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Lt. Col</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>USA</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Cyrus Austin</u>					14. MOTHER'S MAIDEN NAME <u>Mary Mc Vay</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>USA '09-'22 & '27</u>		16. SOCIAL SECURITY NO. <u>215-24-0735</u>		17. INFORMANT ADDRESS <u>Records- US PHS Hospital, Balto, Md.</u>					
18. <u>6-02-01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
					(A) <u>Heart failure</u> DUE TO			<u>Terminal</u>	
					(B) <u>Chronic bronchitis and emphysema</u> DUE TO			<u>Years</u>	
					(C) _____				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (1) (this hospital) attended the deceased from <u>Jan. 11</u> 19 <u>66</u> to <u>Jan. 17</u> 19 <u>66</u> , that (1) (we) last saw the deceased alive on <u>Jan. 17</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Thos. D. McCaffery Jr.</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>1/17/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Thomas D. McCaffery, SA Surgeon (R)</u>					23D. ADDRESS <u>US PHS Hospital, Balto, Md.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1, 19, 66</u>		24C. NAME of CEMETERY or CREMATORY <u>Moreland Memorial</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1966</u>		25B. NAME OF REGISTRAR <u>R. E. E. E.</u>			25C. FUNERAL DIRECTOR <u>Wm. Cook Brooks Towson, 1050 York Rd. #4</u>			ADDRESS	

After a week of

FUNERAL DIRECTOR: IMPORTANT

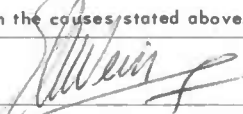
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00666				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 00666	
1. NAME OF DECEASED (Type or Print) KATIE HARE				2. DATE AND HOUR OF DEATH 1/17/66 11:50 Am.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital				A. STATE MD B. COUNTY BALTO					
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore County - Towson					
				D. STREET ADDRESS (If rural, give location) 107 alleyway ave. 52-00					
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 9-30-78	9. AGE (In years last birthday) 87	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife - Teacher Balt-Gtch Md		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JOHN W. NOWELL				14. MOTHER'S MAIDEN NAME LYDIA MORRIS					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. -		17. INFORMANT Daughter & husband		ADDRESS same	
18. 5-78X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Antenatal hemorrhage of unknown etiology				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH 12 hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO					
				(B) DUE TO					
				(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized arteriosclerosis								years	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1/17 1966 to 1/17 1966 , that (I) (we) last saw the deceased alive on 1/17 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Ronald Feldner				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 1/17/66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS Maryland General Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-20-66		24C. NAME OF CEMETERY or CREMATORY IMMANUEL CEMETERY		24D. LOCATION (City, town, or County) (State) GLENCOE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1966		25B. NAME OF REGISTRAR Robert E. Feldner		25C. FUNERAL DIRECTOR Wm. Coyle Brooks		ADDRESS 1050 York Rd Towson, MD 21204			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. <u>66 00667</u>					
BIRTH NO. <u>66 00667</u>					M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) BAIERLIPP, LESTER FRANCIS					2. DATE AND HOUR OF DEATH 1-18-66 5:45A M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) ZONE 29 5370 901 MAIDEN CHOICE LANE					
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH 8-7-06	9. AGE (In years last birthday) 59	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL WORKER			10B. KIND OF BUSINESS OR INDUSTRY ARMCO STEEL		11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOSEPH BAIERLIPP					14. MOTHER'S MAIDEN NAME ELSIE CARMINE					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 217-05-9997		17. INFORMANT MILDRED BARLIPP, 901 MAIDEN CHOICE LANE			ADDRESS 21229		
18. 334X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) RT Bronchopneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Paraplegia, later Resp. paralysis Varicella cerebri medullaris lesion					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO					INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION 1-4-66			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Respiratory Impairment			20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from JANUARY 4, 1966 to JANUARY 18, 1966 that (I) (we) last saw the deceased alive on JANUARY 18, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE 					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) EWALDO WEISS					23D. ADDRESS M.D. CATON & WILKENS AVENUE BALTO MD					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 1/21/66		24C. NAME OF CEMETERY or CREMATORY LOUDON PARK CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1966			25B. NAME OF REGISTRAR Hubbard & Sons			25C. FUNERAL DIRECTOR ADDRESS HUBBARD FUNERAL HOME, 4107 WILKENS AVE. #29				

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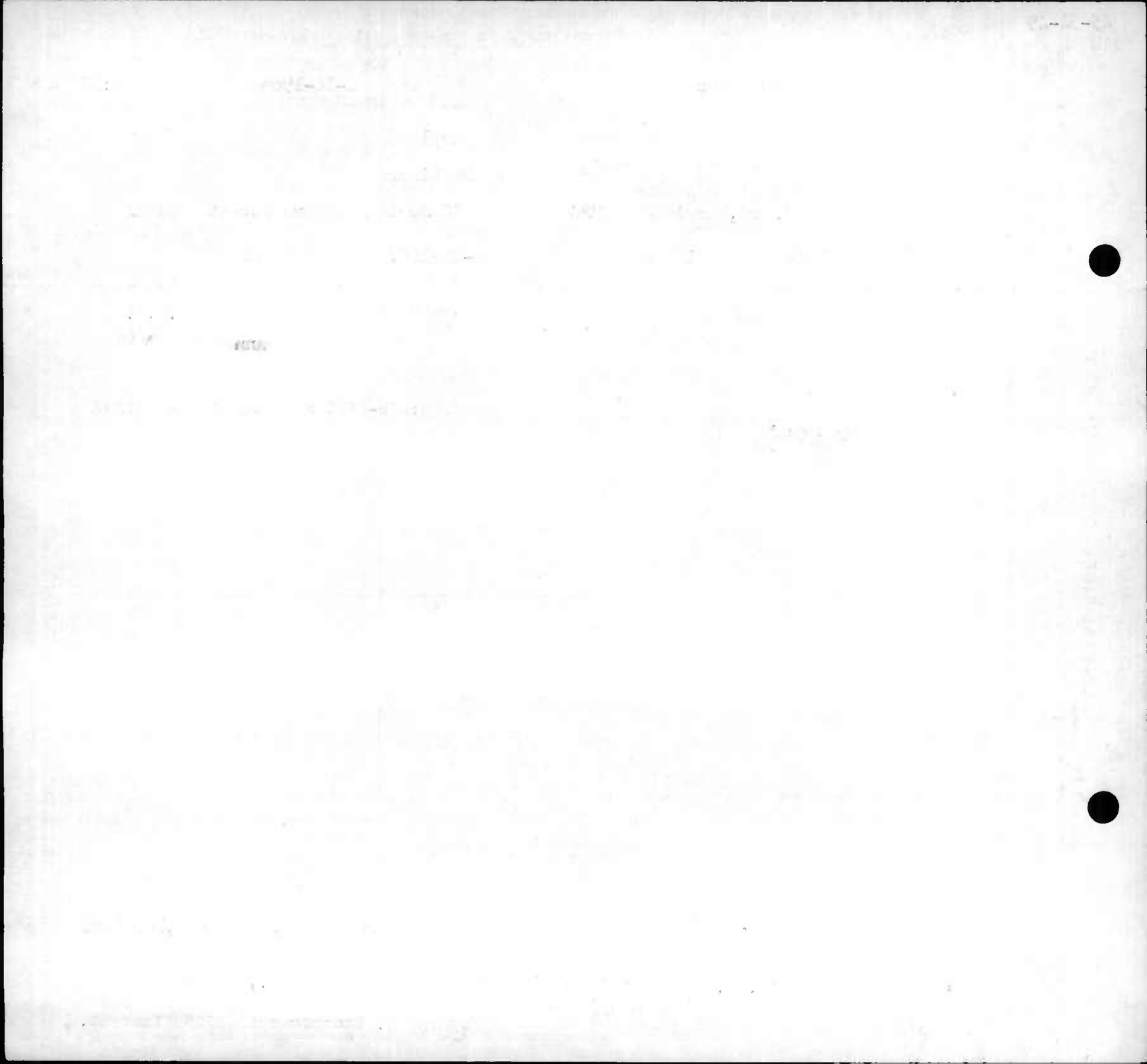
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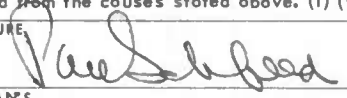
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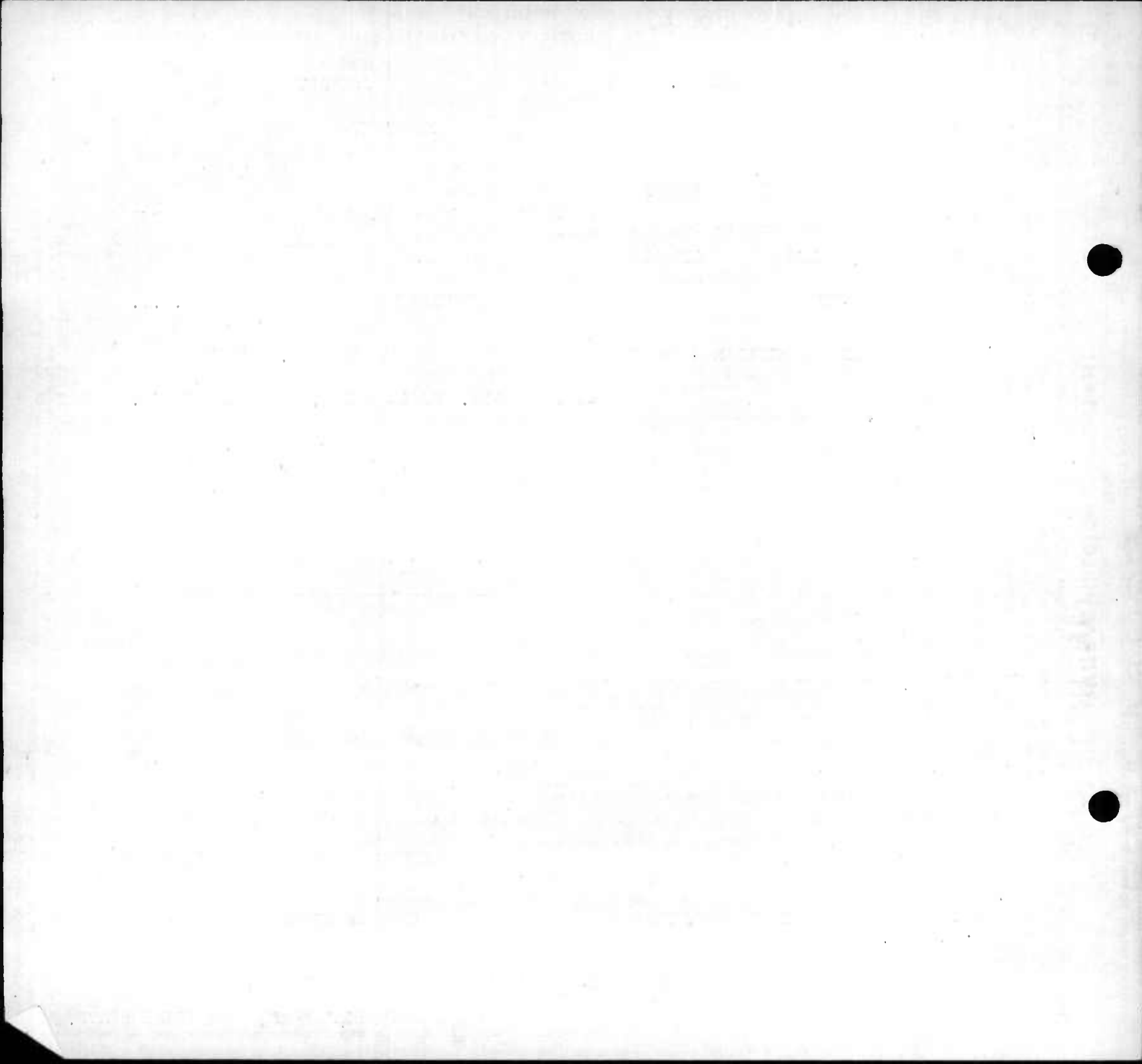
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-120 66 00668				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00668	
BIRTH NO.				CERTIFICATE OF DEATH			
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
Ann Kobus				1-16-1966		5:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY	
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				Maryland		1-03	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				D. STREET ADDRESS (If rural, give location)			
				638 South Montford Street 21224			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
Female		White		Widowed		8-28-1907	
9. AGE (In years last birthday)		10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
58		58		Pennsylvania		U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
Housewife							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Andrew Konerth				Ann Gottschling			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No						Records: BCH-4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 12-28-1965 to 1-16-1966, that (I) (we) last saw the deceased alive on 1-16-1966, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
John R. Burton						1-16-66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
John R. Burton				M.D. 4940 Eastern Avenue, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		Jan. 19, 1966		Oaklawn Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 20 1966		R. E. Taylor		Raymond L. Kaczorowski		2525 Fleet St.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

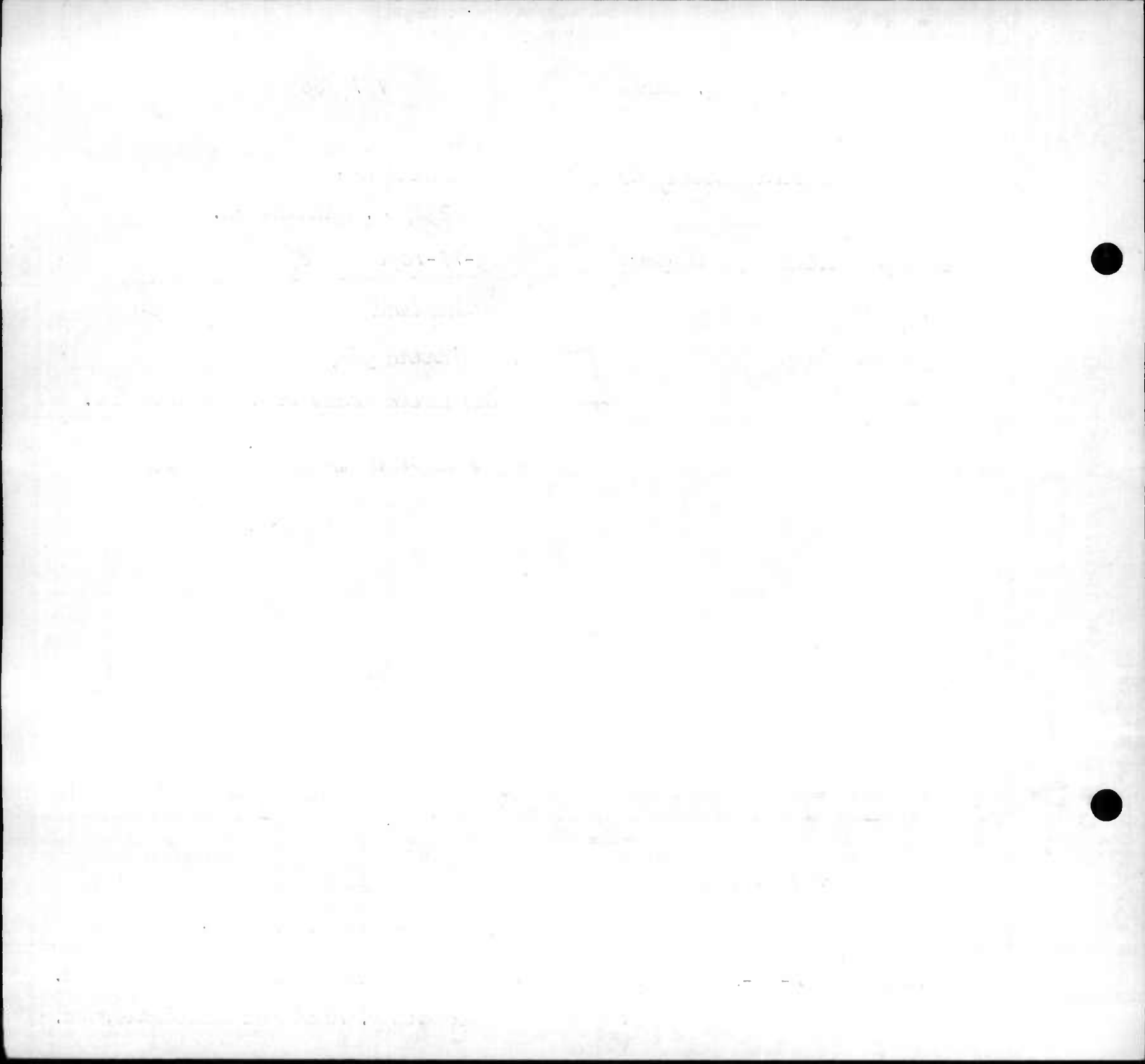
66 00669		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00669	
CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		ELsie C. ARNOLD		JANUARY 17, 1966	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 2240 SIDNEY AVENUE WESTPORT		A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE WESTPORT D. STREET ADDRESS (If rural, give location) 2240 SIDNEY AVENUE 21230			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 6/29/1887	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE	
13. FATHER'S NAME XX WILLIAM WOOD		14. MOTHER'S MAIDEN NAME MARGARET A. MURRAY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. ----		17. INFORMANT ADDRESS MRS. GLADYS KEYES, 2240 SIDNEY AVE. 21230	
18. I		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Arteriosclerotic - C.V.D. DUE TO (B) Cerebral thrombosis DUE TO (C)			8 years One day
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? September 19 65 to Jan 17, 19 66	
22. I certify that (I) (this hospital) attended the deceased from Jan 17, 19 66 and that (I) (we) last saw the deceased alive on Jan 17, 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/18/66	
23C. PHYSICIAN'S NAME (Type) PAUL SCHOENFELD		23D. ADDRESS M.D. 2301 ANNAPOLIS ROAD			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/20/66		24C. NAME of CEMETERY or CREMATORY LOUDON PARK CEMETERY	
24D. LOCATION BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JAN 20 1966			
25B. NAME OF REGISTRAR Hubbard		25C. FUNERAL DIRECTOR ADDRESS HUBBARD FUNERAL HOME, 4107 WILKENS AVE. # 29			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

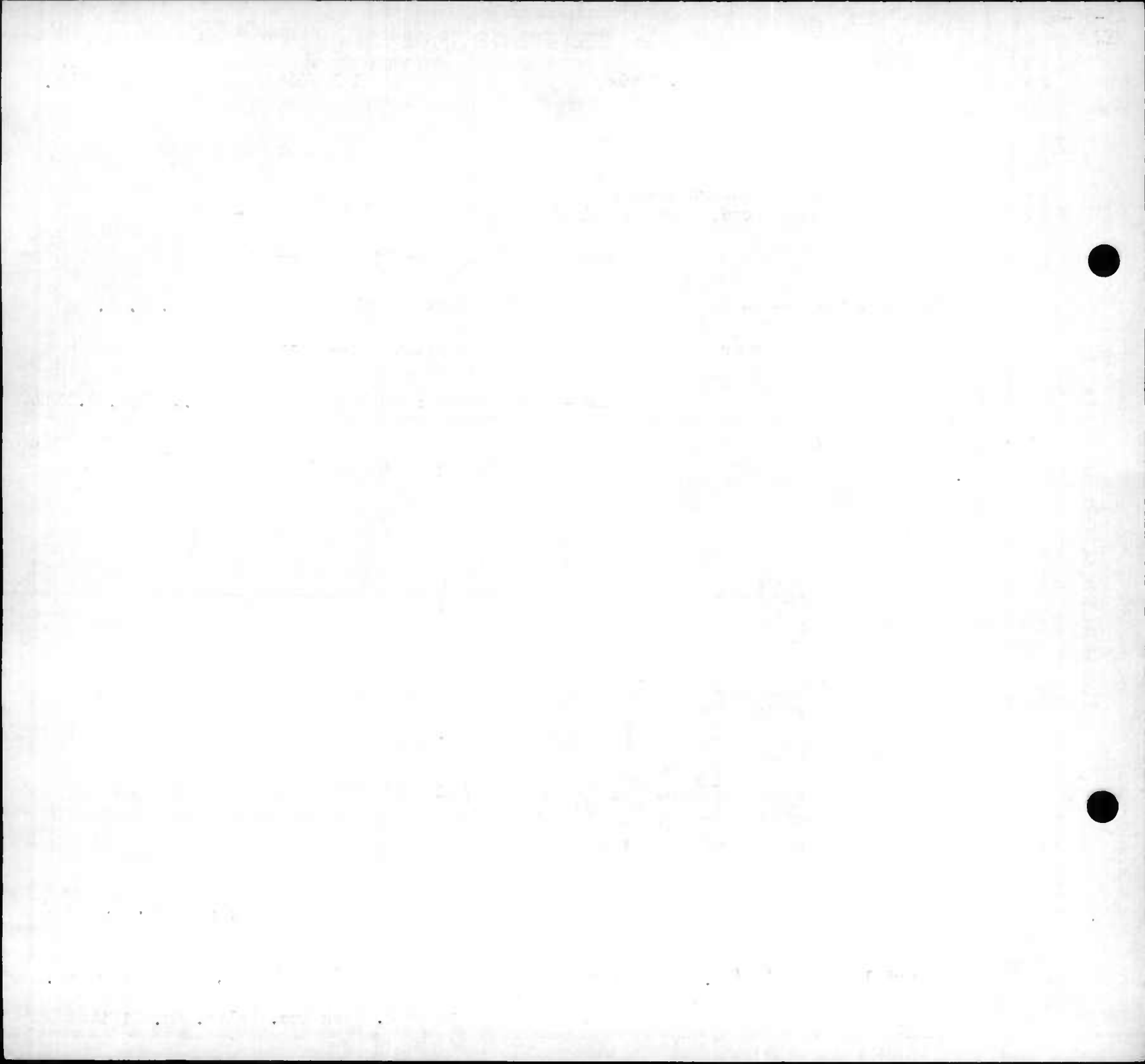
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. <u>66 00670</u>		CERTIFICATE OF DEATH		66 00670	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>Daisy E. Blake</u>		2. DATE AND HOUR OF DEATH <u>1/19/66</u> <u>9</u> <u>00</u> <u>1</u> <u>A.</u> <u>M.</u>			
3. PLACE OF DEATH IN <u>BALTIMORE</u> , <u>MARYLAND</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>12-08</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Melchor Nursing Home</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>2327 N. Charles St.</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>widowed</u>	8. DATE OF BIRTH <u>3-11-1878</u>	9. AGE (In years last birthday) <u>87</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Edward Lippy</u>		14. MOTHER'S MAIDEN NAME <u>Martha Gill</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs Lelia Morey 6641 Walther Ave.</u>	
18. <u>420.0 I</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <u>arteriosclerotic Heart Disease</u>		<u>20 years</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) _____			
		(C) _____			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<u>Perkinsion</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (he) (this hospital) attended the deceased from <u>April 4</u> 19 <u>64</u> to <u>January 19</u> 19 <u>66</u> , that (I) (was) last saw the deceased alive on <u>January 18</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Stanley Z. Felsenberg</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>Jan 19/1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>STANLEY Z. Felsenberg</u>		23D. ADDRESS M.D. <u>1129 E. Baltimore St Baltimore 2, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>1-22-66</u>		24C. NAME of CEMETERY or CREMATORY <u>Hampstead Cemetery</u>	
24D. LOCATION <u>Hampstead</u>		24E. (City, town, or county) (State) <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1966</u>		25B. NAME OF REGISTRAR <u>Leonard J. Ruck Inc</u>		25C. FUNERAL DIRECTOR <u>Baltimore, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

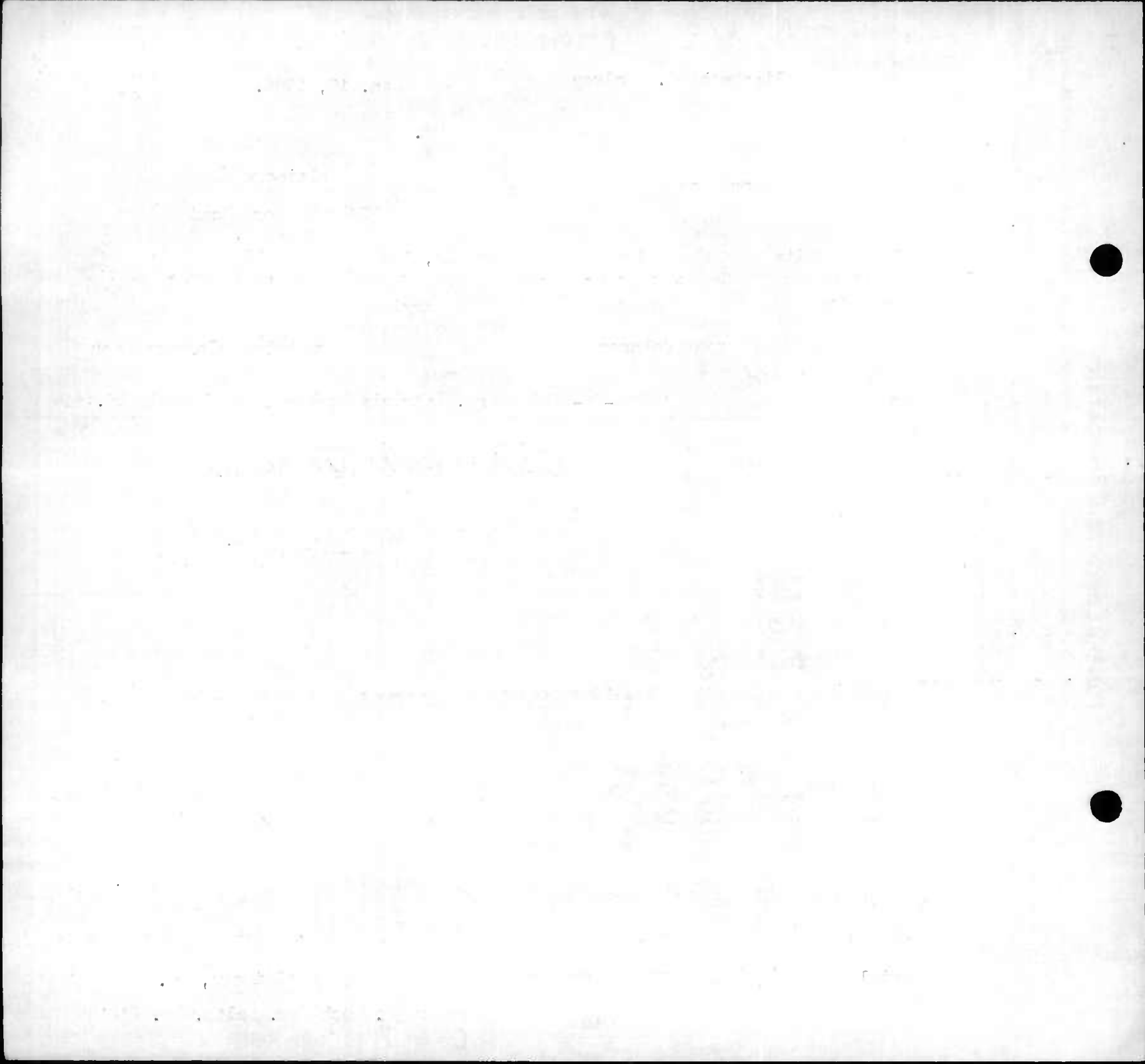
F-656 66 00671		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 00671	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				FARMER, Burley		1/19/66 8:25 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224				A. STATE MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2406 Loch Raven Road - 21218			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH 6/20/20 21	9. AGE (In years last birthday) 45 44	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Worker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Farmer				14. MOTHER'S MAIDEN NAME Rosetta Campbell			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-07-0949		17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Ave., Balto, Md. 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Metastatic Carc. to the brain - primary lung.				INTERVAL BETWEEN ONSET AND DEATH 9 M.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 3/18/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Brain Tumor		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) -		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -			
22. I certify that (I) (this hospital) attended the deceased from 1/2-1/66 19 to 1/19/66 19, that (I) (we) last saw the deceased alive on 1/19/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE S. Kangsurnrith				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/19/66	
23C. PHYSICIAN'S NAME (Type) S. KANGSURNRITH M.D.				23D. ADDRESS 4940 Eastern Avenue, Balto, Md. 21224 Baltimore City Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/23/66.		24C. NAME OF CEMETERY or CREMATORY Farmer Cemetery		24D. LOCATION (City, town, or county) (State) West Jefferson, North Carolina.	
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1966		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
66 00672 CERTIFICATE OF DEATH					Registered No. 66 00672					
BIRTH NO.		M.E. CASE NO.			1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
					Elizabeth V. Halvey			Jan. 19, 1966. 112 Noon M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE Md.					
3734 Old York Road					B. COUNTY 901					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
					Baltimore #18					
					D. STREET ADDRESS (If rural, give location)					
					3734 Old York Road					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
Female	White	Widow		May 12, 1893	72					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife			Own Home		Maryland		USA			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
Edward Oden Johnson					Isabel Florence Oden					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No			215-05-2502		Mrs. Patricia Gerber 5506 Plymouth Rd. #14					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					INTERVAL BETWEEN ONSET AND DEATH					
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)										
ANTECEDENT CAUSES										
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										
II										
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1965 to Jan 19 1966, that (I) (we) last saw the deceased alive on Dec 30 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
23A. SIGNATURE					23B. DATE SIGNED					
Donald W. Mintzer M.D.					1/20/66					
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS					
DONALD W. MINTZER M.D.					3009 EVERGREEN AVE BALTO MD 21214					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)		
Burial		1/22/66.		Loudon Park Cemetery		Baltimore, Md.				
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR ADDRESS				
JAN 20 1966			G. E. Johnson			Leonard J. Ruck Inc. Balto. Md. 21214				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 66 00673	
BIRTH NO. 66 00673							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) Vernon J. Welsh				2. DATE AND HOUR OF DEATH January 19, 1966 4 55 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General		(If not in hospital or institution, give street address or location)		A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-09	
				D. STREET ADDRESS (If rural, give location) 1521 Northgate Road			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never married	8. DATE OF BIRTH 3/22/19	9. AGE (in years last birthday) 46	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY Chesapeake Supply Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Welsh				14. MOTHER'S MAIDEN NAME Mary Sweeney			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes War War II		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Edwin W. Welsh 6313 Leith Walk #12		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 420.11 Coronary Thrombosis				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 14 days	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 5 19 66 to Jan 19 19 66 , that (I) (we) lost saw the deceased alive on Jan 19 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Robert E. Stoner MD				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/19/66	
23C. PHYSICIAN'S NAME (Type) Robert E. Stoner				23D. ADDRESS M.D. Maryland General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/22/66		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1966		25B. NAME OF REGISTRAR Leonard J. Ruck Inc.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214		ADDRESS	

Mr. J. L. ...

W. W.

James M. ...
William ...

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>66 00674</u>	
BIRTH NO. <u>66 00674</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Lindsay, Frances (Daniel)</u>		2. DATE AND HOUR OF DEATH <u>Jan 19-66</u> <u>9:30 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>Union Memorial Hospital</u> <u>Baltimore, Maryland 21218</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>B.</u> B. COUNTY <u>905</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Union Memorial Hospital</u> <u>Baltimore, Maryland 21218</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore, Maryland</u>			
D. STREET ADDRESS (If rural, give location) <u>3226 Ellerslie Avenue</u> <u>Baltimore, Maryland</u>				5. SEX <u>Female</u> 6. RACE <u>Caucasian</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>			
8. DATE OF BIRTH <u>7-22-14</u>		9. AGE (In years last birthday) <u>51</u>		10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.		12. CITIZEN OF WHAT COUNTRY?	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proof RPR</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Port City Press</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina, U.S.A.</u>	
13. FATHER'S NAME <u>James C. Daniel</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Boyd</u>			
15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>248-05-4205</u>		17. INFORMANT <u>Mr. Exum L. Lindsay</u>	
18. ADDRESS (Same)							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Carcinomatous, primary</u> <u>in the left breast</u>				INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>massive Gastrointestinal hemorrhage</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>None</u>							
19A. DATE OF OPERATION <u>July 25-65</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Left Radical Mastectomy</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>No</u>		21C. WHERE DID INJURY OCCUR? <u>No</u>		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) <u>No</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>No</u>			
22. I certify that <u>(H)</u> (this hospital) attended the deceased from <u>Jan 18</u> 19 <u>66</u> to <u>Jan 19</u> 19 <u>66</u> , that <u>(H)</u> (we) last saw the deceased alive on <u>Jan 19</u> 19 <u>66</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above <u>(H)</u> (We) <u>(did)</u> (did not) view the body after death.							
23A. SIGNATURE <u>Kang Fan</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1-19-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>KANG FAN</u>				23D. ADDRESS <u>Union Memorial Hospital</u> <u>Baltimore, Maryland 21218</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/22/66.</u>		24C. NAME OF CEMETERY or CREMATORY <u>Moreland Memorial Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. [unclear]</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc.</u>		ADDRESS <u>Balto. Md. 21214</u>	

Handwritten text at the top of the page, possibly a header or title.

Handwritten text in the upper middle section, including a date "7-22-10" and a signature "Agnes Taylor".

Handwritten text in the middle section, appearing to be a list or series of notes.

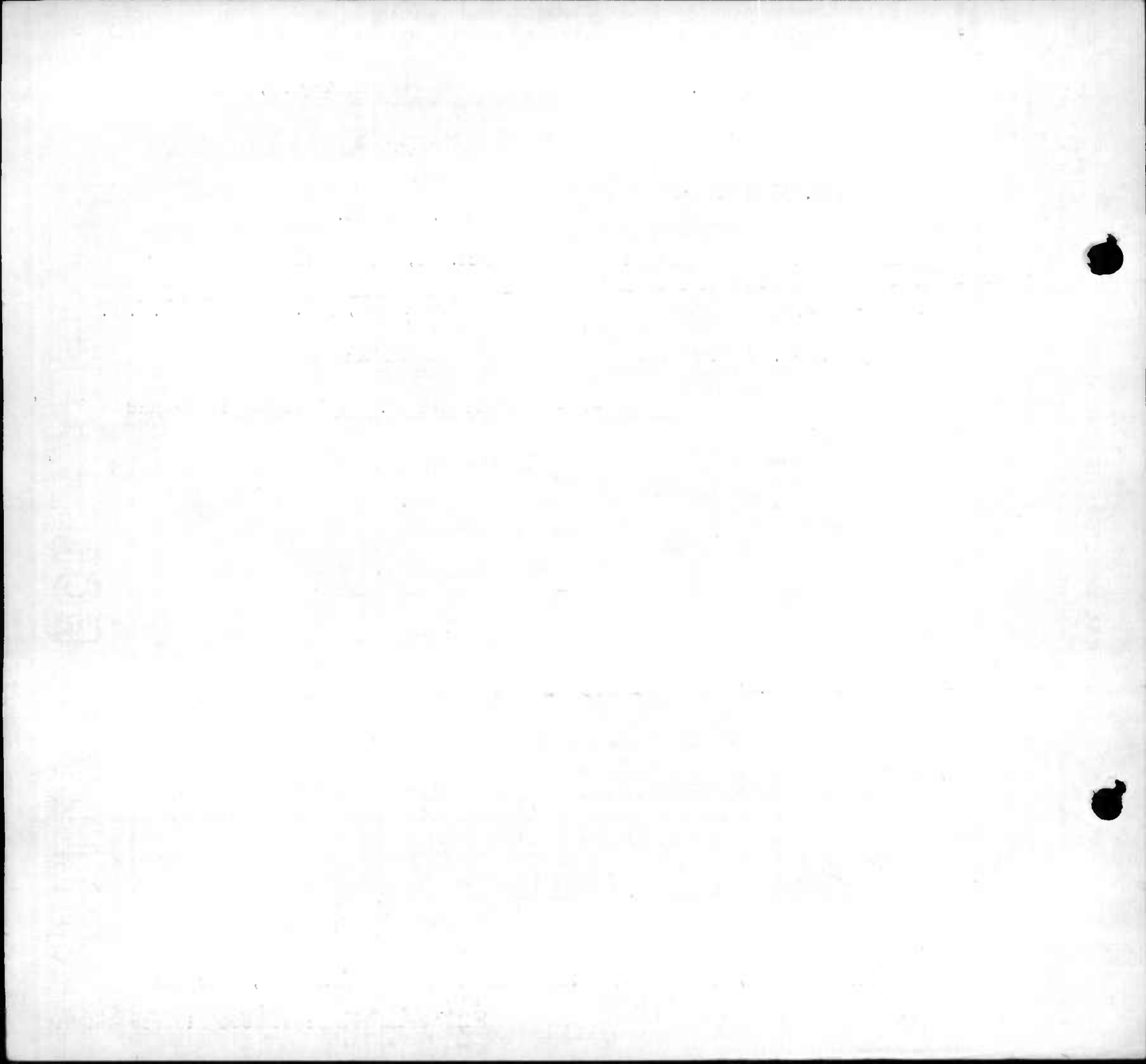
Handwritten text in the lower middle section, including a date "July 22-10" and a signature "Agnes Taylor".

Handwritten text at the bottom of the page, possibly a footer or concluding remarks.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00675		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 00675	
1. NAME OF DECEASED (Type or Print) <div style="text-align: center; font-size: 1.2em;">Evelyn B. Zapf</div>			2. DATE AND HOUR OF DEATH <div style="text-align: center; font-size: 1.2em;">January 18, 1966</div>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <div style="text-align: center; font-size: 1.2em;">4 E. 32nd Street</div>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 12-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4 E. 32nd St.		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH Oct. 16, 1894	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Nurse		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frostburg, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Benjamin W. Deffinbaugh		
14. MOTHER'S MAIDEN NAME Sara Mitchell			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 212-32-0937			17. INFORMANT ADDRESS Richard W. Zapf 13 Maple Avenue		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) 443X1 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertension			CAUSE OF DEATH (A) Arteriosclerotic C.V. D. (B) (C) INTERVAL BETWEEN ONSET AND DEATH 10 yrs 10 yrs		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/9 2/19 1955 to 1/18 1966 , that (I) (we) last saw the deceased alive on 12/9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. Edward Leach				23B. DATE SIGNED 1/19/66	
23C. PHYSICIAN'S NAME (Type) C. EDWARD LEACH				23D. ADDRESS 14 E. Eagle St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/21/66		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 21 1966			
25B. NAME OF REGISTRAR Ellsworth Armacost		25C. FUNERAL DIRECTOR ADDRESS Ellsworth Armacost 4600 Liberty Heights			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00676		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 00676	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH 1/18/66		
1. NAME OF DECEASED (Type or Print) HARRY M. STANSBURY			M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND - B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO D. STREET ADDRESS (If rural, give location) 333 BIGLEY AVE. #27		
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL		(If not in hospital or institution, give street address or location)			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5/30/03	9. AGE (In years last birthday) 62	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY HUCKSTER.		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME RACHEL ?		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO.		17. INFORMANT LUCY STANSBURY 333 BIGLEY AVE. #27	
18. 022X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH RUPTURED AORTIC ANEURYSM (A) RUPTURED AORTIC ANEURYSM DUE TO (B) 3 YPHILIS DUE TO (C) 20MR		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 1-17-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED RUPTURED AORTIC ANEURYSM		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-17-66 19 to 1-18-66 19, that (I) (we) last saw the deceased alive on 1-18-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James H. Jewell				23B. DATE SIGNED 1-18-66	
23C. PHYSICIAN'S NAME (Type) James H. Jewell				23D. ADDRESS UNIVERSITY HOSP, BALTO MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/22/66		24C. NAME OF CEMETERY or CREMATORY Meadowridge	
24D. LOCATION (City, town, or county) (State) Wash Blvd, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 21 1966		25B. NAME OF REGISTRAR R. B. J. J. J.	
25C. FUNERAL DIRECTOR'S ADDRESS 333 Bigley Ave		25D. SIGNATURE OF FUNERAL DIRECTOR [Signature]			

12/20/07

02/20/07

434089

444089

12/20/07 02/20/07

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Richard Alban

2. DATE AND HOUR PRONOUNCED DEAD

1/18/66 4:00 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2235 Southern Rd. # 20

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

9. AGE (In years
last birthday)

31

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Barber

10B. KIND OF BUSINESS OR INDUSTRY

Joe's Barber Shop Maryland

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Edgar Alban

14. MOTHER'S MAIDEN NAME

Esther Carrigo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

Korean War

16. SOCIAL
SECURITY NO.

?

17. INFORMANT

ADDRESS

Shirley M. Alban, 2235 Southern Rd.

18.

E 816.4

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)(A) Crushing injury of chest with fracture of
sternum and ribs, right and right
sided hemothorax

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

York Rd. near Northway

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

1 18 66 3:35a

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

driver in auto-auto collision

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/18/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1/21/66

23C. NAME OF CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

Catonsville, Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

JAN 21 1966

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Austin E. Donovan 3818 Roland Ave

55

1. Southern

Naval

United States Navy

United States Navy

United States Navy

United States Navy

United States Navy

UNITED STATES NAVY

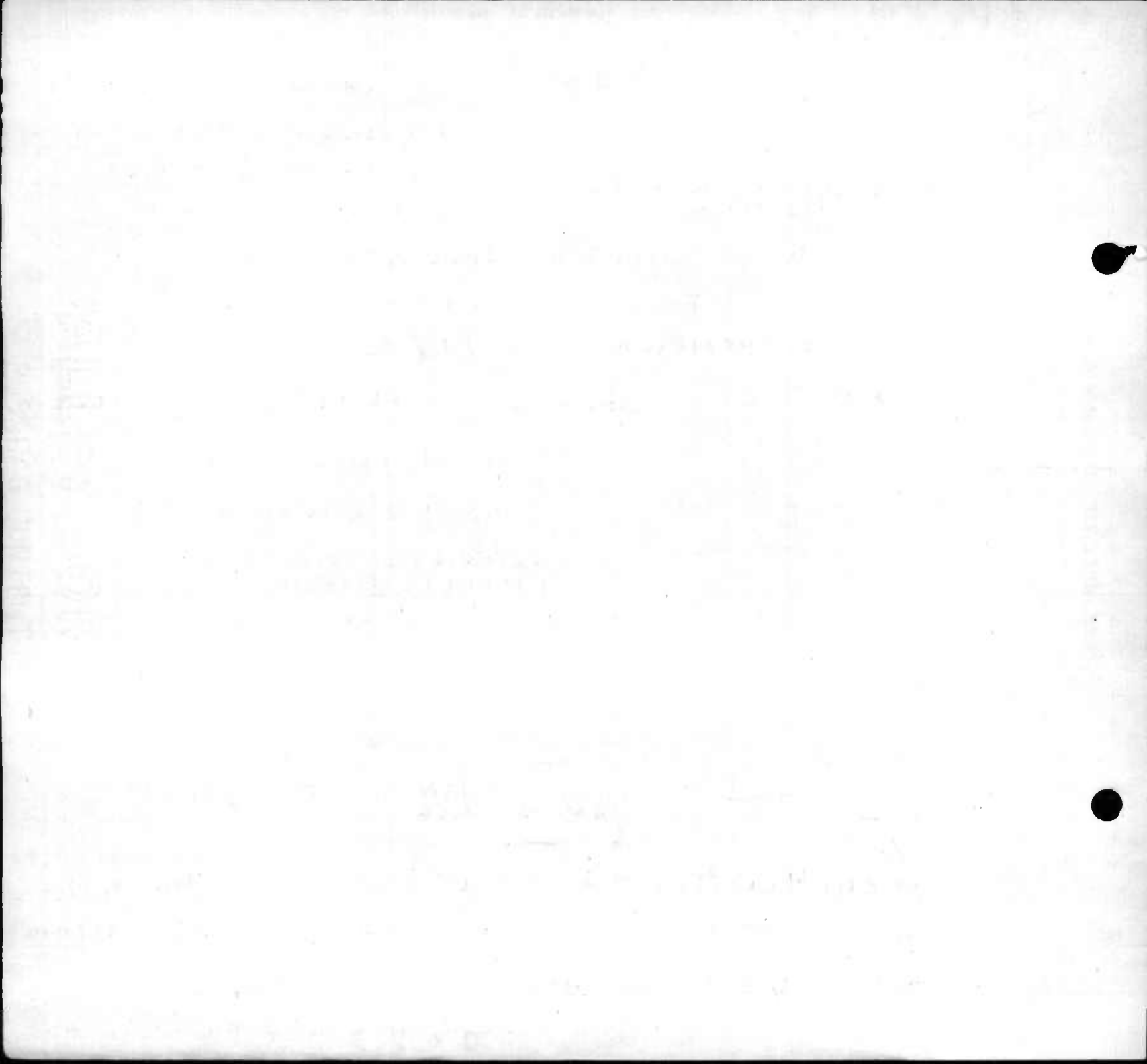
UNITED STATES NAVY

UNITED STATES NAVY

FUNERAL DIRECTOR: IMPORTANT

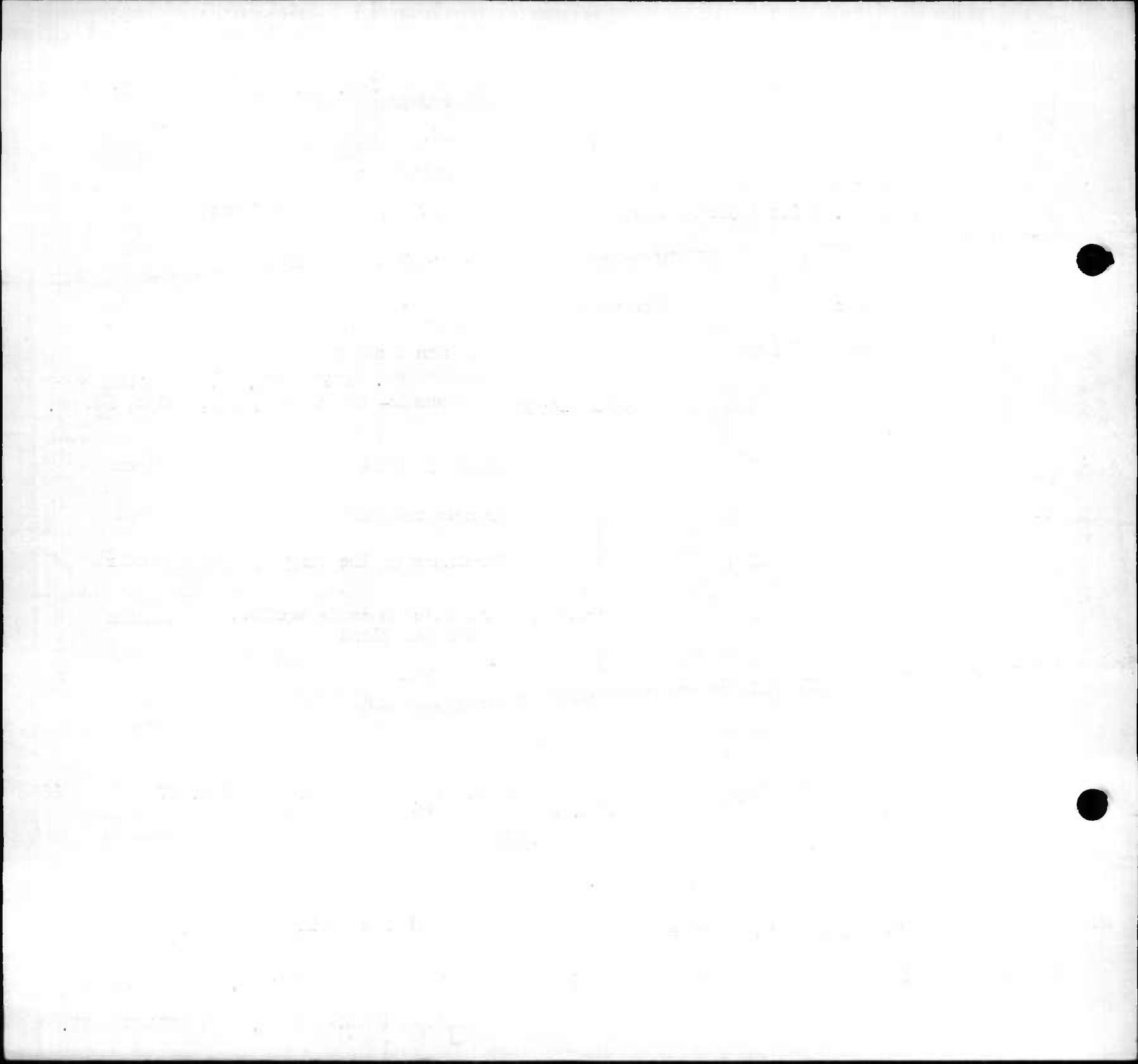
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 66 00678	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 66 00678</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) RACHEL ANN IMHOFF</p> </div> <div> <p>2. DATE AND HOUR OF DEATH JANUARY 17 1966 9:00 P.M.</p> </div> </div>											
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p>3021 KESWICK ROAD BALTIMORE II</p>						<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE MARYLAND B. COUNTY BALTIMORE CITY</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE CITY</p> <p>D. STREET ADDRESS (If rural, give location) 3021 KESWICK ROAD 305</p>					
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH APRIL 26, 1909		9. AGE (In years last birthday) 56		<p>If Under 1 Yr. Months: Days: Hours: Min.</p>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITRESS				10B. KIND OF BUSINESS OR INDUSTRY FOOD		11. BIRTHPLACE (State or foreign country) MONTGOMERY COUNTY				12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN A. THOMPSON						14. MOTHER'S MAIDEN NAME ELAZA GATES					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 213-12-4716		17. INFORMANT DAUGHTER JUNE BEEL ADDRESS 5527 NORTH GREEN					
<p>18. 422.11 CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>INTERVAL BETWEEN ONSET AND DEATH REL</p> <p>(A) CEREBRAL VASCULAR ACCIDENT ACUTE</p> <p>(B) CEREBRAL SCLEROSIS MANY YEARS</p> <p>(C) ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</p> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. MULTIPLE SCLEROSIS</p>											
<p>19A. DATE OF OPERATION 0</p> <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —</p> <p>20A. AUTOPSY? (Yes or No) —</p> <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —</p>											
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR? —			
<p>22. I certify that (I) (this hospital) attended the deceased from JAN. 1959 to JAN. 17 1966, that (I) (we) last saw the deceased alive on JAN. 13 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>											
23A. SIGNATURE Hans J. Koetter M.D.						<p>Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/></p> <p>23B. DATE SIGNED Jan. 17, 1966</p>					
23C. PHYSICIAN'S NAME (Type) HANS J. KOETTER						23D. ADDRESS 5600 HARTFORD ROAD BALTOIX					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 1/21/66		24C. NAME OF CEMETERY or CREMATORY Meadowridge				24D. LOCATION (City, town, or county) (State) Wash Blvd, Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1966				25B. NAME OF REGISTRAR John E. Sullivan				25C. FUNERAL DIRECTOR Justin E. Donovan-3818 Plant ADDRESS —			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

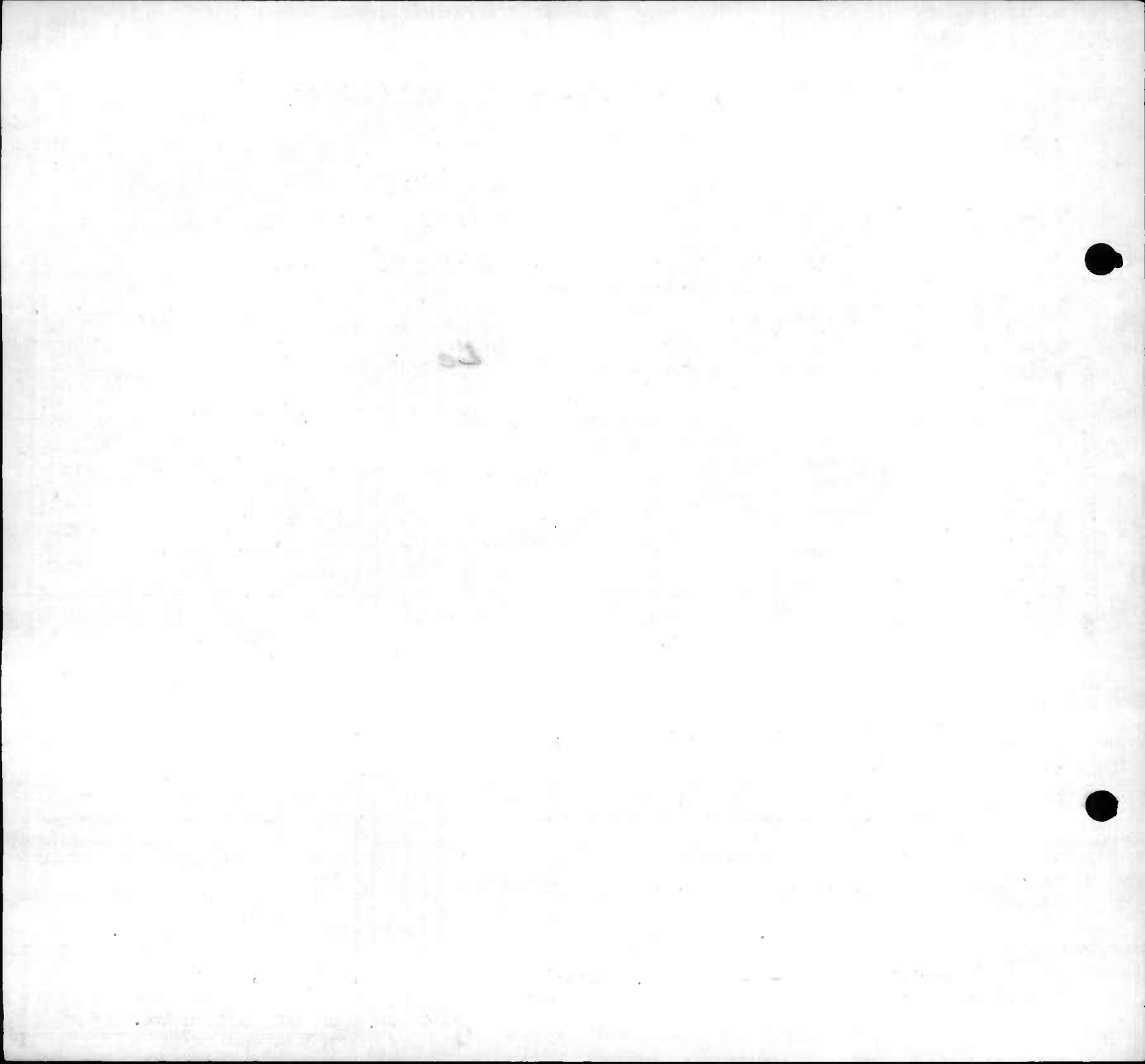
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 00679</u>	
BIRTH NO. <u>66 00679</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>ARTHUR ENLOE</u>		2. DATE AND HOUR OF DEATH <u>Jan. 17, 1966</u> <u>3: 20 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>302</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>US Public Health Service Hospital</u> <u>Wyman Pk. Drive & 31st Street</u>		D. STREET ADDRESS (If rural, give location) <u>1127 E. Baltimore Street</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Divorced</u>	8. DATE OF BIRTH <u>9/25/10</u>	9. AGE (In years last birthday) <u>55</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Messman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Seafarer</u>		11. BIRTHPLACE (State or foreign country) <u>Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Charles Ed. Enloe</u>		14. MOTHER'S MAIDEN NAME <u>Nan Blanton</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>552-22-6708</u>		17. INFORMANT <u>MR. DAVID MUSE, 135 FROMENAC FORREST</u> <u>Records- US PHS Hospital, Balto, Md. MO.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>163 X I</u> <u>Pulmonary edema</u>		CAUSE OF DEATH (A) DUE TO <u>Bronchopneumonia</u> (B) DUE TO <u>Carcinoma of the lung</u> (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>Days</u> <u>Months</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> <u>Cancer, metastatic to cauda equina, & adrenal gland</u>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<u>Months</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(H)</u> (this hospital) attended the deceased from <u>Sept. 28</u> 19 <u>65</u> to <u>Jan. 17</u> 19 <u>66</u> , that <u>(H)</u> (we) last saw the deceased alive on <u>Jan. 17</u> 19 <u>66</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(H)</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Thomas J. Lau</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>1/19/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Thomas J. Lau, Surgeon (R)</u>		23D. ADDRESS M.D. <u>US PHS Hospital, Balto, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1/21/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>LOUDON PARK CEMETERY</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>HUBBARD FUNERAL HOME, 4107 WILKENS AVE. #29</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-346		66 00680		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 00680	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				BUTLER, LAWRENCE		1-19-66		5:35 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY					
				Md.					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE			
MONTEBELLO STATE HOSPITAL				D. STREET ADDRESS (If rural, give location)		1113 Argyle Ave.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
M	C	NEVER MARRIED	6-30-33	32	NOT EMPLOYED	NONE	MARYLAND	USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
SAMUEL BUTLER				Lelia Bailey					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No						Hospital Records			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
443X1				Acute pulmonary Edema				2 1/2 Hrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Hypertensive and Arterio-sclerotic heart disease				UNKNOWN.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from JANUARY 10 1966 to JANUARY 19 1966, that (I) (we) last saw the deceased alive on JANUARY 19 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
Thomas P. Connelly				1-19-66					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
THOMAS P. CONNELLY				MONTEBELLO STATE HOSPITAL.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		1-24-66		Mt. Auburn		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JAN 21 1966		Charles R. Law		Charles R. Law		802 Madison Ave.			



1
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W 426

66 00681

BALTIMORE CITY HEALTH DEPARTMENT

66 00681

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WALTER JOHNSON (WALKER)

2. DATE AND HOUR PRONOUNCED DEAD

January 19, 1966 2:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

749 W. Franklin St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

749 W. Franklin St.

5. SEX

male

6. RACE

negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

May 4, 1892

9. AGE (In years
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Contractor

11. BIRTHPLACE (State or foreign country)

Wilmington, N. C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry Johnson

14. MOTHER'S MAIDEN NAME

Annie Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

WW I

16. SOCIAL
SECURITY NO.

218-01-1598

17. INFORMANT

ADDRESS

Fannie Johnson - 749 W. Franklin St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Malnutrition and dehydration

DUE TO

Cancer of the prostate (history)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Rudiger Breiteneker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-19-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1-24-66

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

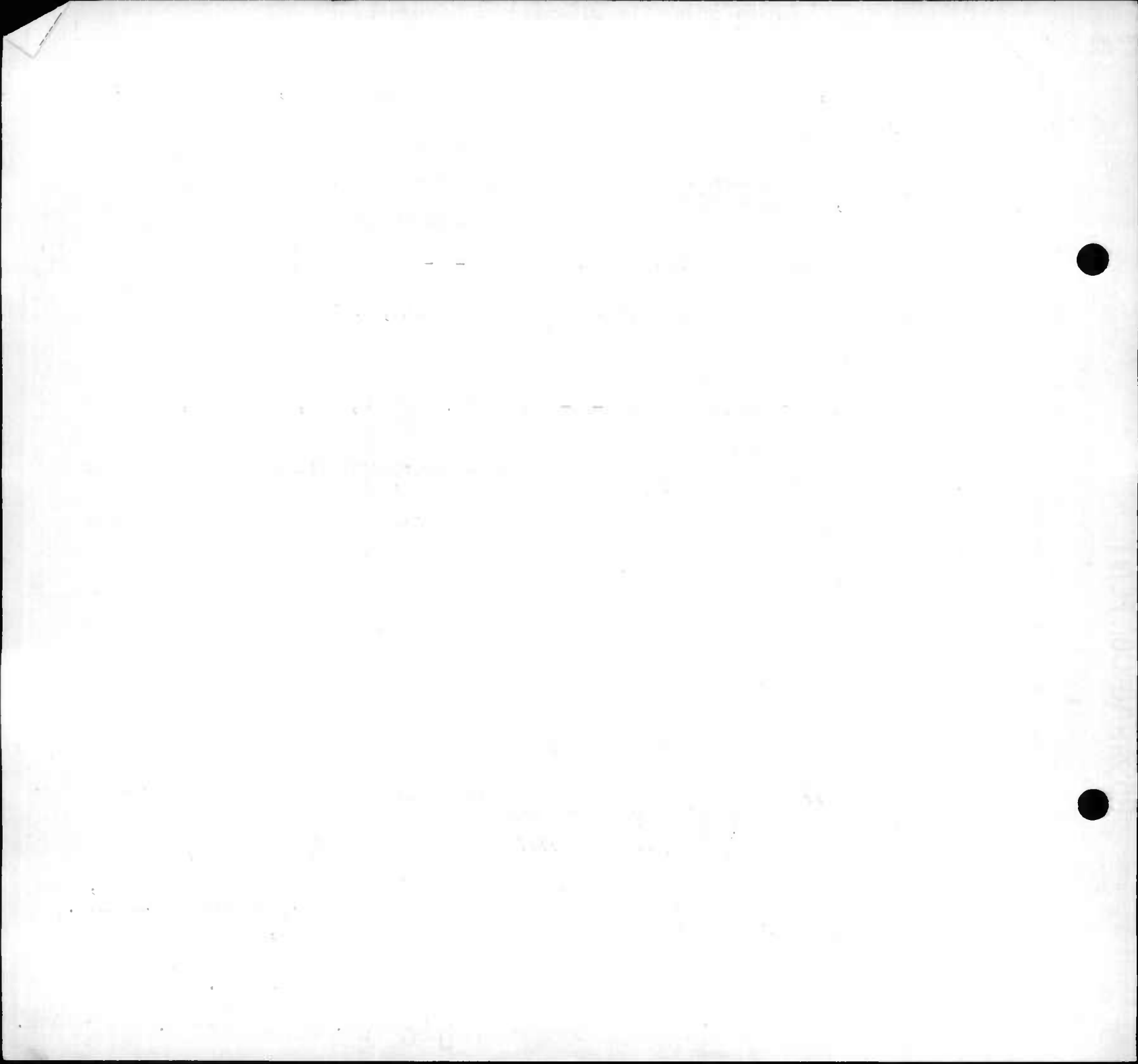
JAN 21 1966

Charles R. Law 802 Madison Ave.

WALTER B. BROWN

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00682		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00682	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) COOK, HARRY EDWARD			2. DATE AND HOUR OF DEATH JANUARY 20, 1966 6:50 a.m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND VETERANS ADMINISTRATION HOSPITAL (If not in hospital or institution, give street address or location) 3900 Loch Raven Boulevard Baltimore, Maryland 21218			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1800 ASHLAND AVENUE		
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 9-24-14	9. AGE (In years last birthday) 51	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COAL BAGGER		10B. KIND OF BUSINESS OR INDUSTRY COAL COMPANY	11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME HARRY COOK			14. MOTHER'S MAIDEN NAME EVELYN BANKS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WORLD WAR II		16. SOCIAL SECURITY NO. 215-01-7147	17. INFORMANT ADDRESS CLIN. RECORDS, VAH, BALTIMORE, MARYLAND		
18. 502.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CHRONIC BRONCHITIS AND EMPHYSEMA INTERVAL BETWEEN ONSET AND DEATH 10 years			(A) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO Cor pulmonale 4 years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(C) DUE TO		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that 17 (this hospital) attended the deceased from January 19th 19 66 , January 20th 19 66 , that 1 (we) last saw the deceased alive on January 20th 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. 17 (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>William B. Joy</i>			23B. DATE SIGNED January 20, 1966		
23C. PHYSICIAN'S NAME (Type) WILLIAM B JOY			23D. ADDRESS VA HOSPITAL 3900 Loch Raven Blvd. Baltimore, Maryland 21218		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 1/24/66	24C. NAME OF CEMETERY or CREMATORY Balto National Cemetery Balto., Md.	24D. LOCATION (City, town, or county) (State) Balto., Md.		
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1966		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>	25C. FUNERAL DIRECTOR ADDRESS William C. March 928 E. North Ave.		



K 652

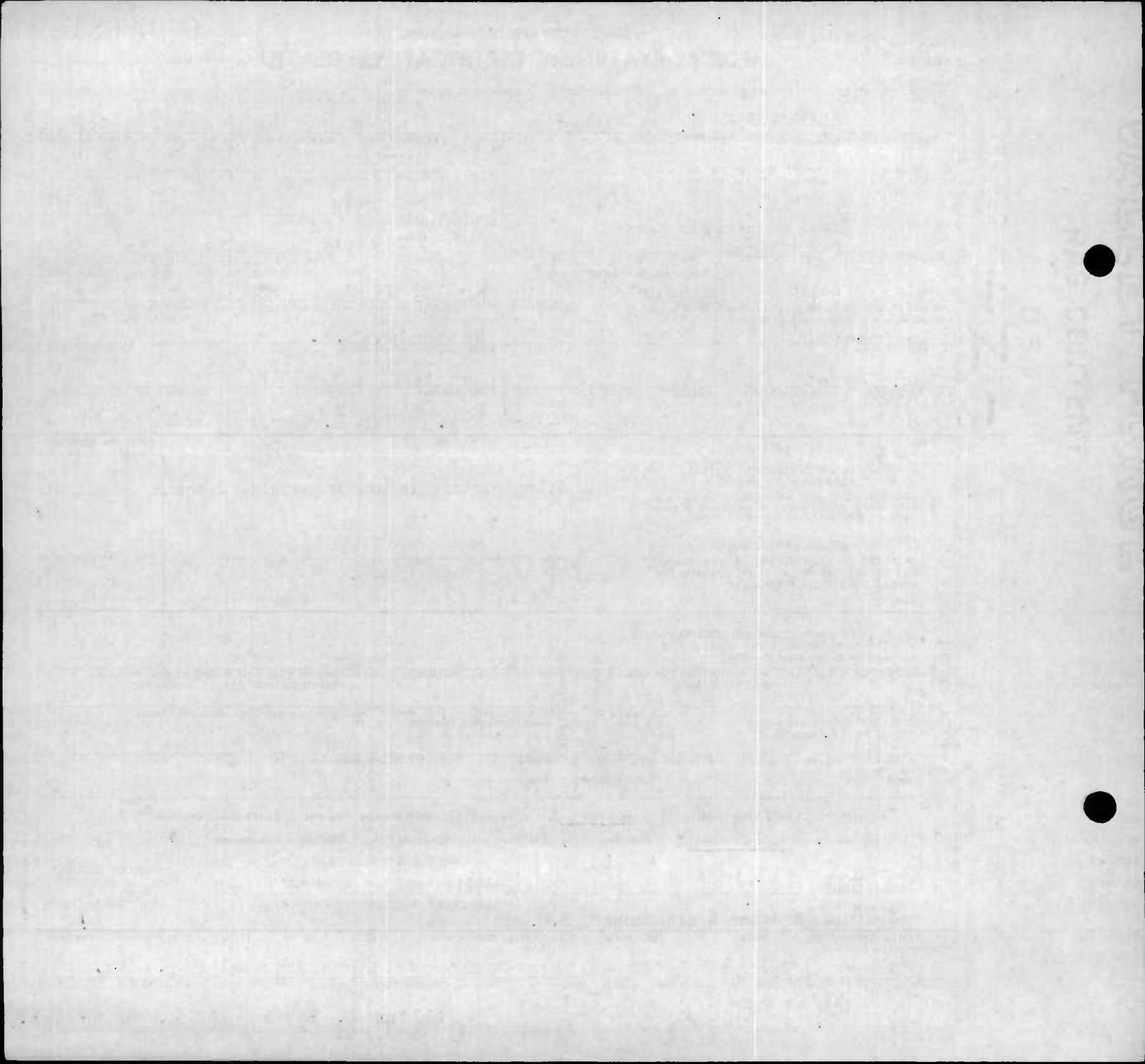
66 00683

BALTIMORE CITY HEALTH DEPARTMENT

66 00683

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
ALEXANDER (KERNS) KERNES		January 18, 1966 2:50 P.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital		A. STATE Maryland B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
		Baltimore	
		D. STREET ADDRESS (If rural, give location)	
		2326 Druid Park Drive	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH
male	negro	Married	Mar 13, 1907
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday)
Engineer			58
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Gastonia, N.C.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John Kernes		Bessie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT
No		217-07-6880	Mrs. Helen L. Kernes
		2326 Druid Pk Dr	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Arteriosclerotic cardiovascular disease	
DUE TO			
19. ANTECEDENT CAUSES		(B) DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
(C) DUE TO			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)
0			no
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)	WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Rudiger Breiteneker, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE	23C. NAME OF CEMETERY or CREMATORY
Burial	1/22/66	Mt Calvary Cemetery	
23D. LOCATION (City, town, or county) (State)		Anne Arundel Cty., Md.	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR
JAN 21 1966		Robert E. Fisher, M.D.	William C. March
		928 E. North Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00684		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 00684	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Patrick O'Halloran		2. DATE AND HOUR OF DEATH Jan. 19, 1966	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Harford Guest Home		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 9-06 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, D. STREET ADDRESS (If rural, give location) 2926 Harford Ave.			
5. SEX Male	6. RACE wh	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Nov. 1, 1880	9. AGE (In years last birthday) 85	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ireland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James O'Halloran			14. MOTHER'S MAIDEN NAME Mary Barrett		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no no		16. SOCIAL SECURITY NO. 107 07 9716	17. INFORMANT Records		
18. 422.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Chronic myocarditis DUE TO (B) Myocardial degeneration DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs -	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) /	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 15 1963 to Jan 19 1966, that (I) (we) last saw the deceased alive on Jan 19 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Thomas J. Kenny</i>				23B. DATE SIGNED Jan 20 1966	
23C. PHYSICIAN'S NAME (Type) S. TANKENBACH		23D. ADDRESS M.D. 150 E. Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 1-21-66	24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1966		25B. NAME OF REGISTRAR Robert E. Smith		25C. FUNERAL DIRECTOR Thomas J. Kenny, Inc 1600 Hollins St	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 00685	
BIRTH NO. 66 00685		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Augustus Daniels		2. DATE AND HOUR OF DEATH 1/16/66 1:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hosp				A. STATE Maryland		B. COUNTY 12-04	
				C. CITY OR TOWN Baltimore		D. STREET ADDRESS (If rural, give location) 2230 N. Calverton St	
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) separated		8. DATE OF BIRTH	9. AGE (In years last birthday) 44	10. Under 1 Yr. Months Days 10 0 0	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Daniels				14. MOTHER'S MAIDEN NAME Annie			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 224-12-4966		17. INFORMANT Mrs Evelyn Daniels		ADDRESS 417 E Chase St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 330 X I subarachnoid hemorrhage, massive fracture				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1/15 19 66 to 1/16 19 66, that (I) (we) last saw the deceased alive on 1/16 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Hudson Fesche				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/16/66	
23C. PHYSICIAN'S NAME (Type) HUDSON FESCHE				23D. ADDRESS UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/22/66		24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1966		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W North Ave.	

THE UNIVERSITY OF CHICAGO PRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. <u>65 00686</u>					
BIRTH NO. <u>66 00686</u>										
M.E. CASE NO.										
1. NAME OF DECEASED (Type or Print) <u>Catherine Taylor</u>					2. DATE AND HOUR OF DEATH <u>Jan. 18, 1966</u> <u>9:40 P.M.</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u>					A. STATE <u>Maryland</u> B. COUNTY <u>1002</u>					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>					
					D. STREET ADDRESS (If rural, give location) <u>938 Webb Court Zone 2</u>					
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>		8. DATE OF BIRTH <u>1/25/32</u>	9. AGE (In years last birthday) <u>33</u>	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>					10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George A Holmes</u>					14. MOTHER'S MAIDEN NAME <u>Carrie Logan</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>215-28-3469</u>		17. INFORMANT <u>Medical records</u>		ADDRESS	
18. <u>260X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <u>UREMIA</u> DUE TO (B) <u>CHRONIC RENAL Dis.</u> DUE TO (C) <u>DIABETES MELLITUS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>~ 4 months</u> <u>~ 6 months</u> <u>- 20 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION <u>2 NONE</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>Jan. 12</u> 19 <u>66</u> to <u>Jan. 18</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Jan. 18</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <u>Richard D. Briggs Jr</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>18 Jan 66</u>			
23C. PHYSICIAN'S NAME (Type) <u>RICHARD D. Briggs Jr</u>					23D. ADDRESS <u>UNIVERSITY HOSP.</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/22/66</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn Cemetry</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1966</u>			25B. NAME OF REGISTRAR <u>Adolphus Hallstead</u>			25C. FUNERAL DIRECTOR <u>1206 W North Ave</u>			ADDRESS	

Catherine Taylor

Jan 13, 1906

University Hospital

F N Married

Wife

George A. Holmes

212-22-3467 Medical records

Carrie Logan

Baltimore Md

N 2A

338 West Court

1/2-2/32 32

Baltimore

Married

Wife

John

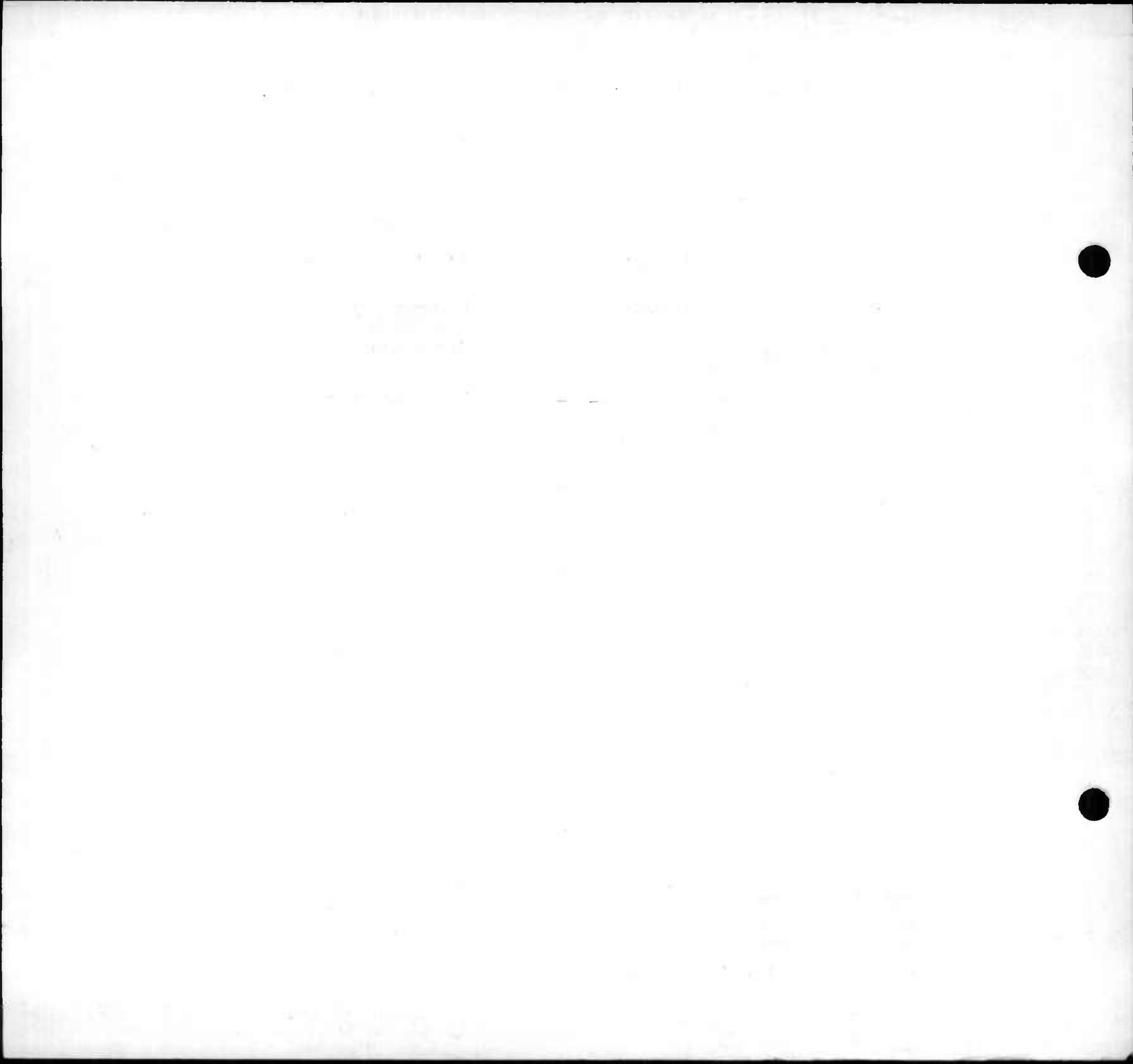
Jan 12, 1906

Jan 12, 1906

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 00687					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 66 00687				
1. NAME OF DECEASED (Type or Print) John James Maker Lansdale					2. DATE AND HOUR OF DEATH January 18, 1966 M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 770 W Saratoga St					A. STATE Maryland				
					B. COUNTY				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
					D. STREET ADDRESS (If rural, give location) 770 W Saratoga St				
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single		8. DATE OF BIRTH 8/28/08	9. AGE (In years last birthday) 57	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10B. KIND OF BUSINESS OR INDUSTRY Factory		11. BIRTHPLACE (State or foreign country) St Marys County Md			12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Yemar Lansdale					14. MOTHER'S MAIDEN NAME Nina Hammond				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 212-14-8272		17. INFORMANT ADDRESS Miss Eleanor Lansdale 770 W Saratoga St		
18. 443X1+322.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive Cardiovascular disease					CAUSE OF DEATH (A) DUE TO mean				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic Alcoholism					(B) DUE TO 5 yr				
					(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 5/8 1964 to 1/18/65 19 that (I) (we) last saw the deceased alive on 1/4 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE W. Atwell Jones					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) W. Atwell Jones					23D. ADDRESS M.D. 554 Paulphin St Baltimore				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/24/66		24C. NAME OF CEMETERY or CREMATORY New Cathdral Cemetry			24D. LOCATION (City, town, or county) (State) Baltimore Md		
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1966			25B. NAME OF REGISTRAR Adolphus Halstead		25C. FUNERAL DIRECTOR ADDRESS Adolphus Halstead 1206 W North Ave				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 66-01394 66 00688					CERTIFICATE OF DEATH					Registered No. 66 00688									
M.E. CASE NO.					2. DATE AND HOUR OF DEATH														
1. NAME OF DECEASED (Type or Print) WALLACE, Baby Girl					1-19-66					8.04 P M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)														
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL					A. STATE MARYLAND					B. COUNTY 6-05									
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE														
					D. STREET ADDRESS (If rural, give location) 1714 E. FAYETTE STREET														
5. SEX FEMALE		6. RACE NEGRO		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED		8. DATE OF BIRTH 1-18-66		9. AGE (In years last birthday)		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME BILLIE HOWARD					14. MOTHER'S MAIDEN NAME BARBARA WALLACE														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT					ADDRESS							
18. 773.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										CAUSE OF DEATH (A) Hyaline Membr. Dis. DUE TO (B) Prematurity DUE TO (C)					INTERVAL BETWEEN ONSET AND DEATH 20 hrs 20 hrs				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) yes					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>1/18</u> 19 <u>66</u> to <u>1/19</u> 19 <u>66</u> , that (I) <u>we</u> last saw the deceased alive on <u>1/19</u> 19 <u>66</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) (did not) view the body after death.																			
23A. SIGNATURE <u>J. O. Winkelstein</u> M.D.										23B. DATE SIGNED <u>1/19/66</u>									
23C. PHYSICIAN'S NAME (Type) J. O. WINKELSTEIN										23D. ADDRESS <u>1203 Cathedral</u>									
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION					24B. DATE 1-20-66					24C. NAME OF CEMETERY or CREMATORY The Johns Hopkins Hos.					24D. LOCATION (City, town, or county) (State) Baltimore, Maryland				
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1966					25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>					25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL					ADDRESS				

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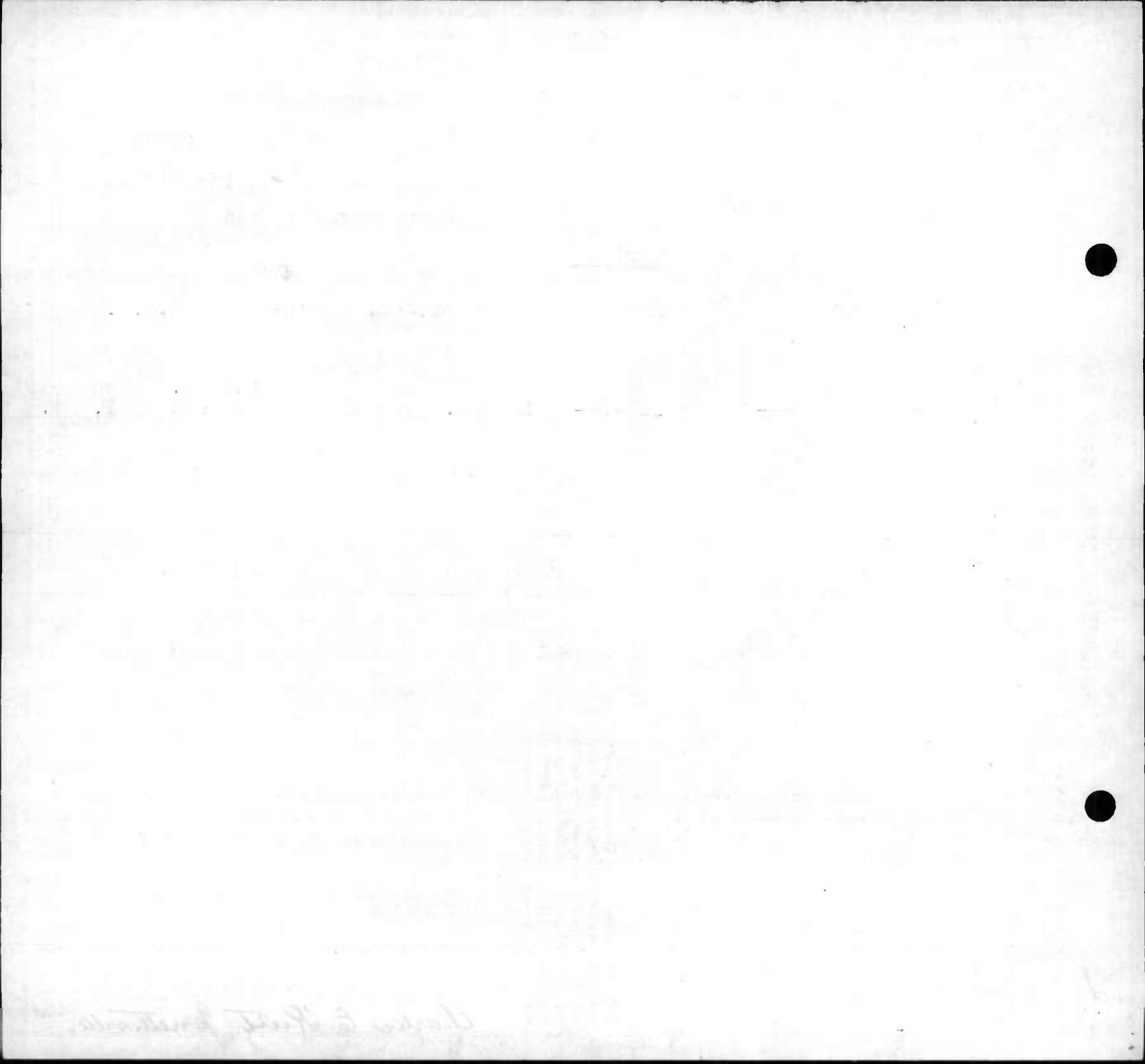
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00689	
BIRTH NO. 66 00689		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Catherine E. Hogarth</i>		2. DATE AND HOUR OF DEATH <i>1/18/1966</i> <i>2</i> <i>45</i> <i>P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hosp</i>		A. STATE <i>Maryland</i> B. COUNTY <i>Harford</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Forest Hill (Rural) 62-00</i>			
		D. STREET ADDRESS (If rural, give location) <i>Jarrettsville Road</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>3/2/90</i>	9. AGE (In years last birthday) <i>75</i>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	
13. FATHER'S NAME <i>Henry Goedeke</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-54-0981</i>		17. INFORMANT <i>Mrs. Kenneth Todd Forest Hill, Md.</i>	
18. <i>345X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Multiple sclerosis 40 yrs</i>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1/10</i> 19 <i>66</i> to <i>1/18</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>1/18</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Adam Fesche</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>1/18/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Hudson Fesche</i>		23D. ADDRESS <i>M.D.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/21/1966</i>		24C. NAME OF CEMETERY or CREMATORY <i>Most Holy Redeemer</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 21 1966</i>			
25B. NAME OF REGISTRAR <i>Charles E. Kuntz</i>		25C. FUNERAL DIRECTOR <i>Jarrettsville, Md.</i>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

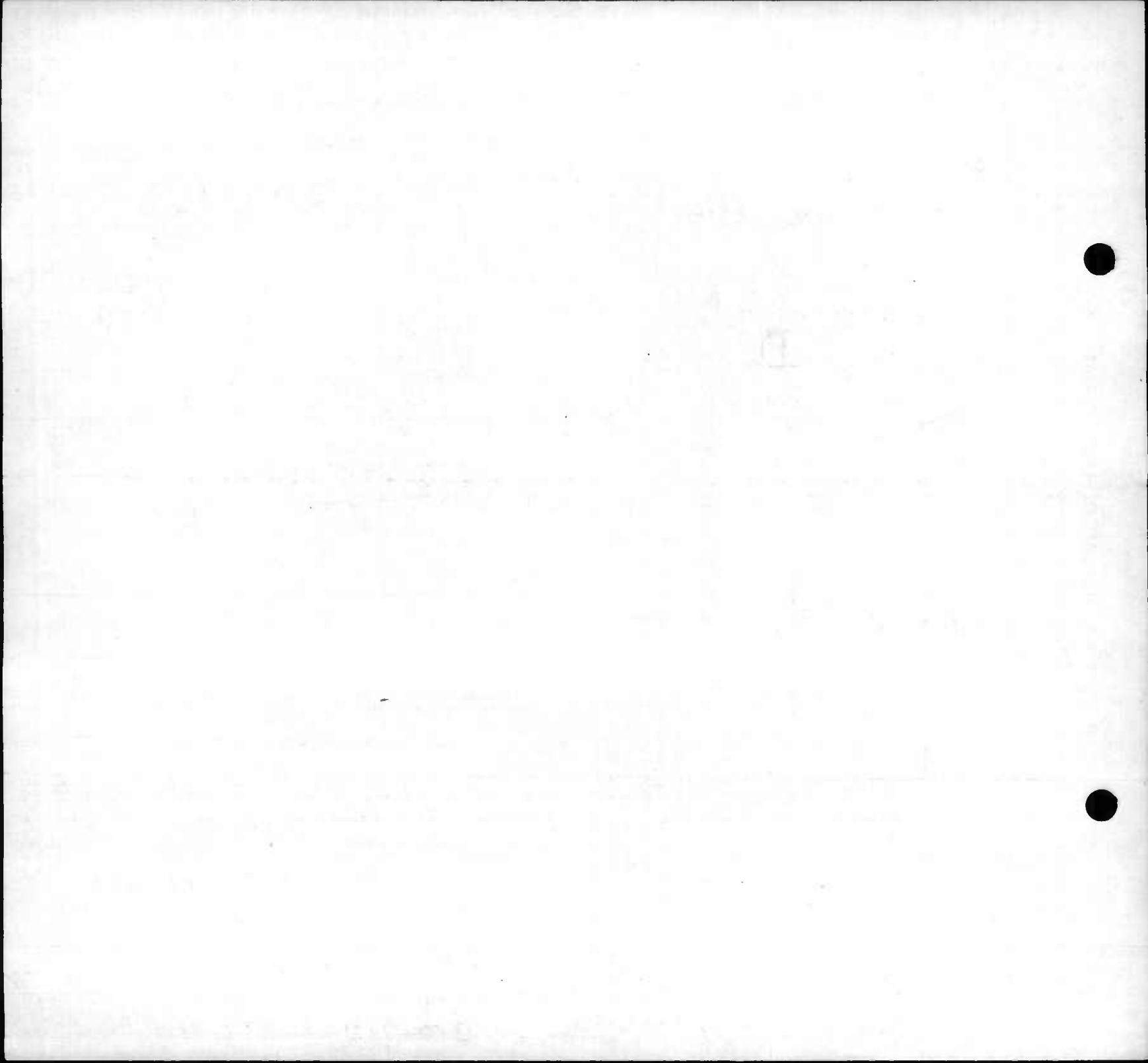
FUNERAL DIRECTOR: IMPORTANT

BIRTH NO. 66 00690		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 00690	
M.E. CASE NO.		1. NAME OF DECEASED Daniel Sadowski		2. DATE AND HOUR OF DEATH 1/20/66 7:10 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		C. (If outside city limits, write RURAL and give township)			
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL BALTIMORE 5, MD		D. STREET ADDRESS (If rural, give location) 1716 THAMES STREET		E. CITY (If rural, give location)			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 9-20-29	9. AGE in years (last birthday) 36	10. If Under 1 Yr. Months: Days: Hours: Min.	11. If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY Social Security Office		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WALTER STEPHEN SADOWSKI		14. MOTHER'S MAIDEN NAME MARY GALASKA		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-34-9890	
17. INFORMANT Mrs. Mary Sadowski		ADDRESS 1716 Thames St.		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypotension Pancreatitis Dehydration Chronic Alcoholism Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 1 week 2 days	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1/20/66 to 1/20/66, that (I) (we) last saw the deceased alive on 1/20/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE E. Eugene Page		23B. DATE SIGNED 1/20/66			
23C. PHYSICIAN'S NAME (Type) E. Eugene Page		23D. ADDRESS Johns Hopkins Hospital		23E. FUNERAL DIRECTOR George A. Weber		23F. ADDRESS 705 S. Ann St. #21231	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/24/66		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1966		25B. NAME OF REGISTRAR E. Sadowski		25C. FUNERAL DIRECTOR George A. Weber		25D. ADDRESS 705 S. Ann St. #21231	

FUNERAL DIRECTOR: IMPORTANT

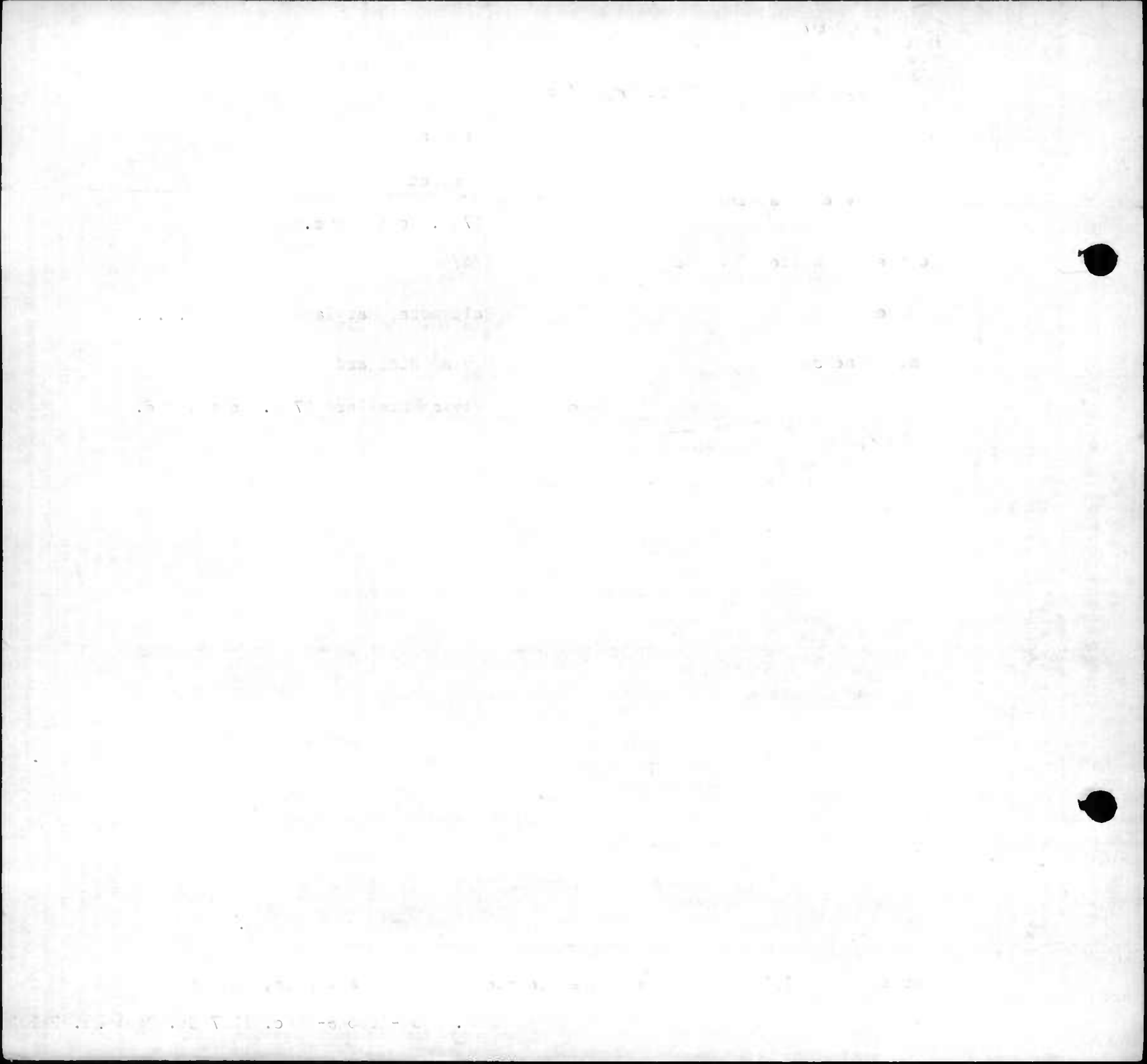
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 66 00691					CERTIFICATE OF DEATH					Registered No. 66 00691									
1. NAME OF DECEASED (Type or Print) Dowling, George V					2. DATE AND HOUR OF DEATH 1/16/66 1230 A.M.														
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 28-04														
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital Baltimore, Maryland					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore					D. STREET ADDRESS (If rural, give location) 3 S. Beechfield Ave.									
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 5/4/89		9. AGE (In years last birthday) 76		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Genl.					10B. KIND OF BUSINESS OR INDUSTRY TRANSIT CO.					11. BIRTHPLACE (State or foreign country) Maryland					12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Joseph Dowling					14. MOTHER'S MAIDEN NAME Nice Owens														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES NO W.W.I					16. SOCIAL SECURITY NO. 213-10-2605					17. INFORMANT Hospital Chart					ADDRESS				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Cancer of the Bladder Metastasis + Hemorrhage										INTERVAL BETWEEN ONSET AND DEATH									
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.																			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION 0					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from 1/15 19 66 to 1/16 19 66 , that (I) (we) last saw the deceased alive on 1/16 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE J. Stephen Margolis										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED 1/16/66				
23C. PHYSICIAN'S NAME (Type)										23D. ADDRESS									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 1-19-66					24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem.					24D. LOCATION (City, town, or county) (State) Baltimore Md.				
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1966					25B. NAME OF REGISTRAR George E. Taylor					25C. FUNERAL DIRECTOR George E. Taylor					ADDRESS 6601 Federal Ave.				



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. <u>66 00682</u>	
BIRTH NO. <u>66-00341</u> <u>66 00682</u>										CERTIFICATE OF DEATH	
M.E. CASE NO. <u>66 00682</u>										1. NAME OF DECEASED (Type or Print) <u>VIVIAN STALLARD (Baby)</u>	
2. DATE AND HOUR OF DEATH <u>1/18/66</u> <u>7:20</u> A.M.											
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Mercy Hospital</u>										4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Hampden</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Aberdeen</u> D. STREET ADDRESS (If rural, give location) <u>27 E. Belair Ave.</u>	
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Baby</u>	8. DATE OF BIRTH <u>1/4/66</u>	9. AGE (In years last birthday) <u>14</u>	If Under 1 Yr. Months: Days: Hours: Min.	10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Gary Blackson</u>										14. MOTHER'S MAIDEN NAME <u>Vivian Stallard</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>										16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Vivian Stallard</u>										ADDRESS <u>27 E. Belair Ave.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Meningitis - septic</u> DUE TO (A) <u>Q. coli.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Prematurity</u> DUE TO (B) <u>12 days</u> (C) <u>12 days</u>										INTERVAL BETWEEN ONSET AND DEATH <u>72 hr.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <u>2</u>										19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>Yes</u>										20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>										21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)											
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)										21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?											
22. I certify that (I) (this hospital) attended the deceased from <u>1/18</u> <u>1/4/</u> <u>19 66</u> , that (I) (we) lost saw the deceased alive on <u>1/18</u> <u>19 66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>[Signature]</u>										23B. DATE SIGNED <u>1/18/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>[Signature]</u>										23D. ADDRESS <u>Mercy Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>										24B. DATE <u>1/20/66</u>	
24C. NAME of CEMETERY or CREMATORY <u>Glen Haven Cemetery</u>										24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1966</u>										25B. NAME OF REGISTRAR <u>[Signature]</u>	
25C. FUNERAL DIRECTOR <u>Wm. Cook-Brooks - Inc.</u>										ADDRESS <u>1217 St. Paul St. 21202</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

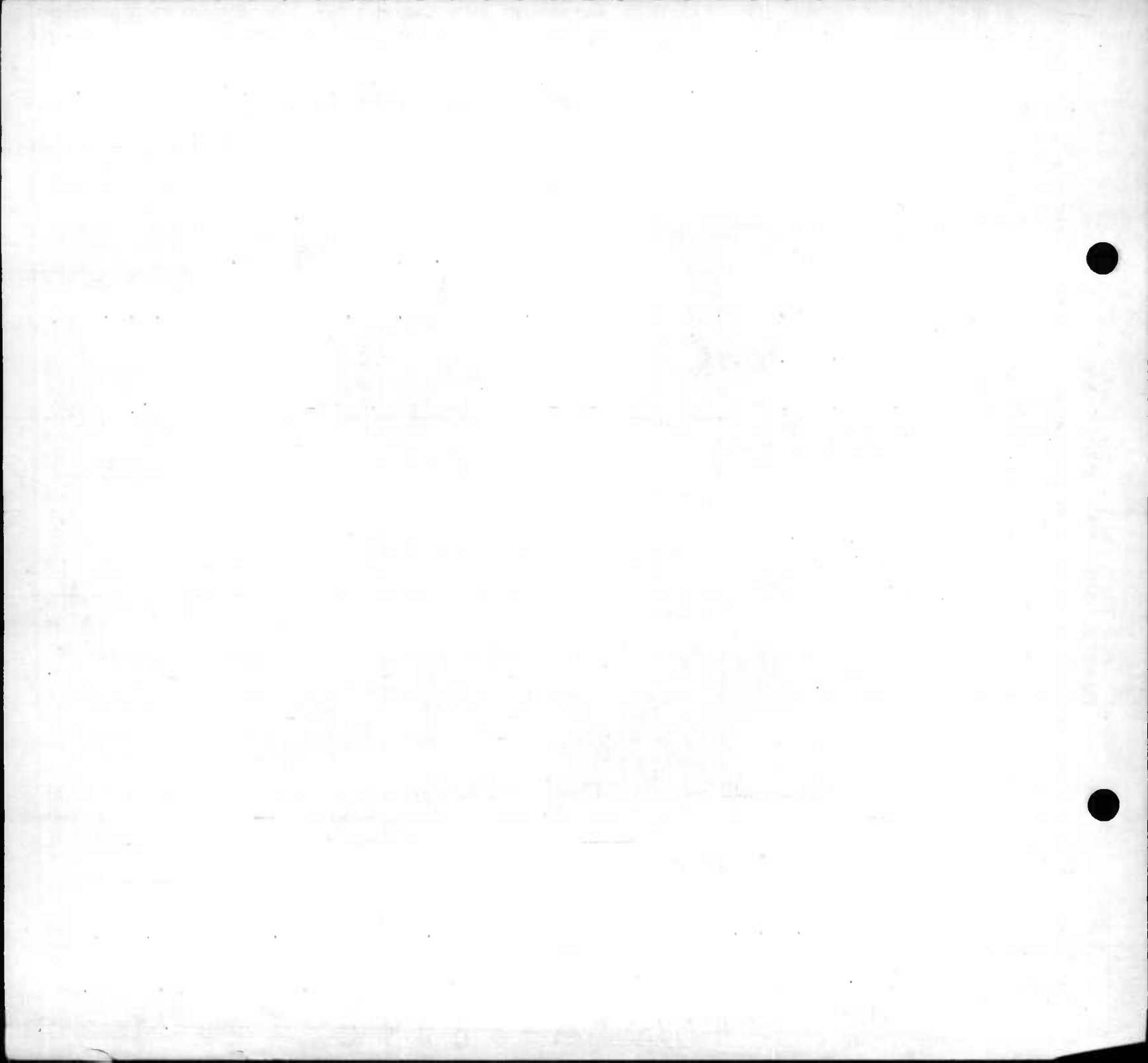
BALTIMORE CITY HEALTH DEPARTMENT											
66 00693					66 00693						
BIRTH NO.					M.E. CASE NO.						
1. NAME OF DECEASED					2. DATE AND HOUR OF DEATH						
(Type or Print) LOUISE SR. M. R.SAL. (M. CABE)					1/17/1966 8:19 PM. M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)						
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL					A. STATE MD. B. COUNTY 27-15						
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE					D. STREET ADDRESS (If rural, give location) MT. ST. AGNES, MT. WASHINGTON 2						
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)			
F.		W		SINGLE		5/16/89		76			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
RELIGIOUS SISTER OF MERCY			RELIGIOUS SISTER OF MERCY			Maryland			USA		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
CHARLES M. CABE						ELLA MCINTYRE					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
								SR. M. CYRIL RSM MT. ST. AGNES CONVENT			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH						CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)						(A) Myocardial infarct					
ANTECEDENT CAUSES						(B) A.S.H.D.					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(C) _____					
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
0											
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
<input type="checkbox"/>											
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?				
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9:05 AM. 1/17 19 66 to 8:19 PM. 1/17 19 66 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 1/17/ 19 66 and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.											
23A. SIGNATURE								23B. DATE SIGNED			
Maria Pia Caldini M.D.								1/17/66			
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS					
MARIA PIA CALDINI M.D.						MERCY HOSP.					
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		24C. NAME OF CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)			
BURIAL			1/20/66		Mt. St. AGNES CEMETERY			Mt. WAS. BALTO. MD.			
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR ADDRESS					
JAN 21 1966			John E. T. T. T.			H.W. MEARS & SON 805 N. CALVERT ST.					

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH										Registered No. 66-00694
BIRTH NO. 66 00694		M.E. CASE NO.								
1. NAME OF DECEASED (Type or Print) Margaret G. Welsh						2. DATE AND HOUR OF DEATH January 18, 1966 10 A. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1727 Light St.				
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) divorced		8. DATE OF BIRTH Sept. 20, 1898		9. AGE (In years last birthday) 67 yrs.		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant Com. Sta. City of Balto.				10B. KIND OF BUSINESS OR INDUSTRY City of Balto.			11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Curry						14. MOTHER'S MAIDEN NAME Jane Curley				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no none				16. SOCIAL SECURITY NO. 217-16-5955		17. INFORMANT John Richard Welsh-808 Lynvue Rd. 21090				
18. <u>443X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH (A) Hypertensive cardiovascular disease years DUE TO (B) DUE TO (C) DUE TO				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION <u>2</u> none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) -		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? -				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) none		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -						
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -						
22. I certify that (I) this hospital attended the deceased from February 7, 1957 to January 6, 1966, that (I) we last saw the deceased alive on January 6, 1966 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we did (did not) view the body after death.										
23A. SIGNATURE <i>C. C. Chiu</i>						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1-19-66		
23C. PHYSICIAN'S NAME (Type) Dr. C.C. Chiu				23D. ADDRESS M.D. 1 E. Randall St. Balto. Md. 21230						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/21/66		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Old Frederick Rd. Balto. Md.				
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1966				25B. NAME OF REGISTRAR <i>Robert J. ...</i>		25C. FUNERAL DIRECTOR KRAUSE FUNERAL HOME 1216 S. Charles St.				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 00685					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 66 00685				
1. NAME OF DECEASED (Type or Print) Sister Mary Theresa Douglas					2. DATE AND HOUR OF DEATH January 19, 1966 8.57 a. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland, B. COUNTY Baltimore				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Villa Saint Michael					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
					D. STREET ADDRESS (If rural, give location) 4000 Forest Hill Road				
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single (never m.)		8. DATE OF BIRTH Aug. 7, 1879	9. AGE (In years last birthday) 86	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) San Francisco, California		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James				14. MOTHER'S MAIDEN NAME Mary (?)					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Sister Mary Louise - 4000 Forest Hill Road			
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. If means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) Cardiovascular collapse DUE TO Generalized arteriosclerosis (B) DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH two weeks three years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from August 19 19 63 to January 18 19 66, that (I) (we) last saw the deceased alive on January 18 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED January 19, 1966					
23C. PHYSICIAN'S NAME (Type) Samuel P. Pabian				23D. ADDRESS M.D. 3326 Tudor City					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/21/66		24C. NAME of CEMETERY or CREMATORY St. Joseph's Cemetery		24D. LOCATION (City, town, or county) (State) Emmitsburg, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Stewart & Mowen Co., 108 N. North Ave.					

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C-540

66 00696

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 00696

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) KIERON CONLEY (Father Kiernan Conley)		2. DATE AND HOUR PRONOUNCED DEAD January 18, 1966 6:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Seton Institute 6400 Reisterstown Rd.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Indiana C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore St. Meinrad D. STREET ADDRESS (If rural, give location) 6400 Reisterstown Rd. St. Meinrad Arch	
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Oct. 16, 1927
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Priest		10B. KIND OF BUSINESS OR INDUSTRY Religion	9. AGE (In years last birthday) 38
11. BIRTHPLACE (State or foreign country) Green Bay, Wisconsin		12. CITIZEN OF WHAT COUNTRY? Abbey.	
13. FATHER'S NAME Harry L. Conley		14. MOTHER'S MAIDEN NAME Julia Thomas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT: Records ADDRESS Seton Institute, 6400 Reisterstown Rd., City
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cranio-cerebral injuries ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) DUE TO (B) DUE TO (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) yes
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) woods	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Seaton Psychiatric Institute
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 1-18-66 ?		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? Found lying on ground; apparently fell
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Rudiger Breitenecker, M.D. M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Rudiger Breitenecker, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-19-66			
23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23B. DATE Jan. 22, 1966	23C. NAME OF CEMETERY or CREMATORY St. Meinrad Arch Abbey
24A. DATE REC'D BY HEALTH DEPT. JAN 21 1966		24B. NAME OF REGISTRAR St. Meinrad Arch	24C. FUNERAL DIRECTOR Stewart & Mowen Co., 108 W. North Av., City

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VALLEY FORD

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BALTIMORE CITY HEALTH DEPARTMENT

66 00697

BIRTH NO.

66 00697

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Odella Colby				2. DATE AND HOUR PRONOUNCED DEAD 1/17/66 6:50 p. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 741 W. Franklin St.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 17-03 D. STREET ADDRESS (If rural, give location) 741 W. Franklin St.			
5. SEX female	6. RACE colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH Aug	9. AGE (In years last birthday) 55	10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ind		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Harry Miller			14. MOTHER'S MAIDEN NAME Olivia Myers				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Wm. Brown 1734 Ellwood St			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) 443X I Arteriosclerotic and hypertensive cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <u>Werner U. Spitz</u> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 1/21/66		23C. NAME OF CEMETERY or CREMATORY Mt. Calvary		23D. LOCATION (City, town, or county) (State) D. A. County, Md	
24A. DATE REC'D BY HEALTH DEPT. JAN 21 1966		24B. NAME OF REGISTRAR Robert E. Jenkins		24C. FUNERAL DIRECTOR Staff L. Lock		ADDRESS 1304 N. Central St	

WALTER RONGE

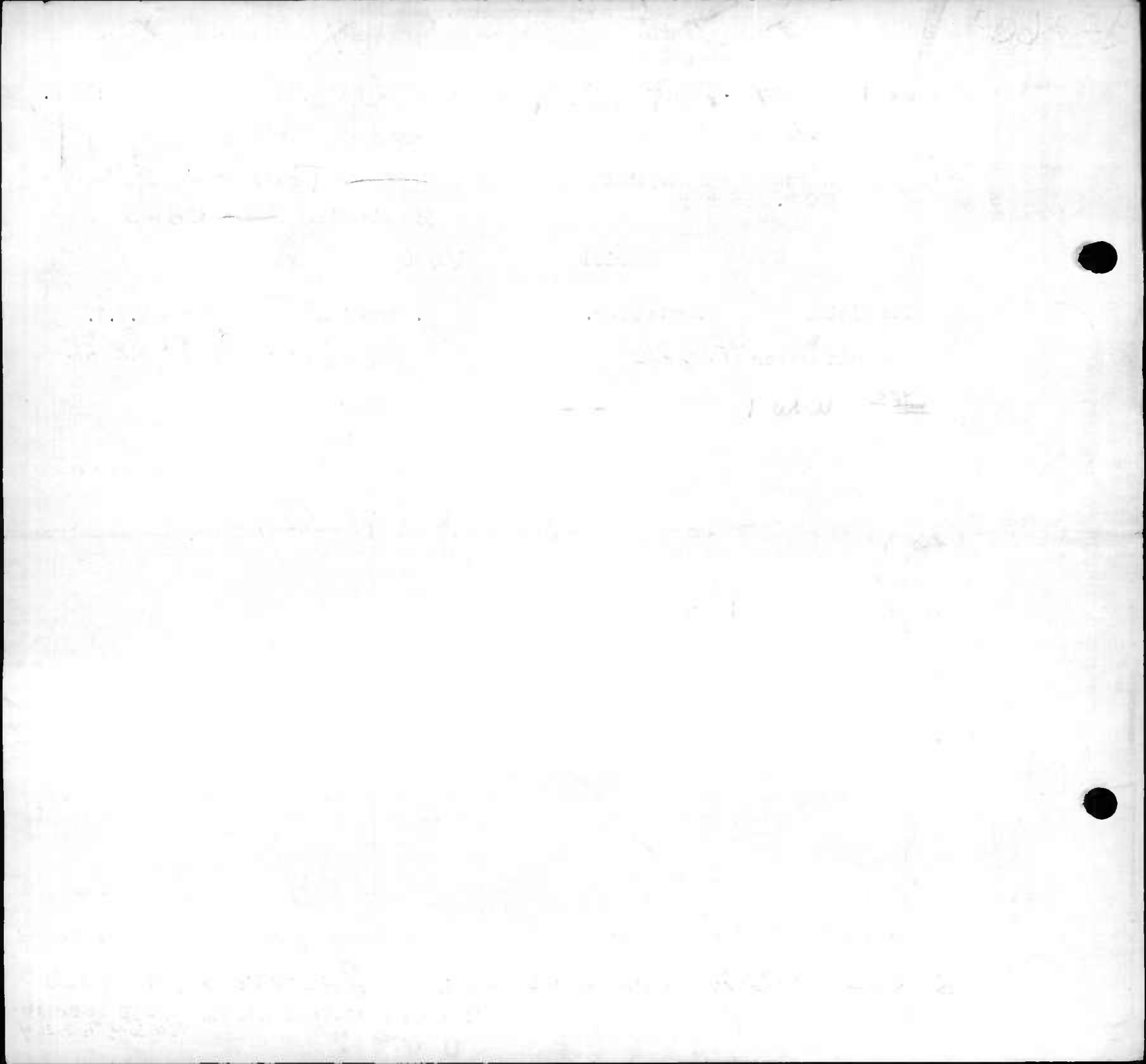
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00698		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00698	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Henry M. Yeager		2. DATE AND HOUR OF DEATH 1/20/66 6:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hospital 100 N. Broadway		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland 21204 B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Towson 53-00 D. STREET ADDRESS (If rural, give location) 554 Picadilly Street Road			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1/1/96	9. AGE (In years lost birthday) 70	10. Under 1 Yr. Months Days 10. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Technician		10B. KIND OF BUSINESS OR INDUSTRY Dental Lab.		11. BIRTHPLACE (State or foreign country) N. Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ma rtin Luther YEAGER		14. MOTHER'S MAIDEN NAME Laura Virginia BUFFINGTON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. 216-32-8586		17. INFORMANT Self	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) 336.11		CAUSE OF DEATH (A) ASPHYXIA (B) RESPIRATORY PARALYSIS (C) AMYOTROPIC LATERAL SCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH MINUTES 7 YEAR 7 YEAR	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. MEDICAL CERTIFICATION 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1-20-66 to 1-20-66, that (I) (we) last saw the deceased alive on 1-20-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ephraim B. Barzaga		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-20-66	
23C. PHYSICIAN'S NAME (Type) EPHRAIM B. BARZAGA		23D. ADDRESS M.D. CHURCH HOME & HOSPITAL - BALTO. 31, 2nd			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-22-66		24C. NAME OF CEMETERY or CREMATORY LORRAINE PARK	
24D. LOCATION BALTIMORE MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JAN 21 1966			
25B. NAME OF REGISTRAR P. L. B. 2. F. J. J.		25C. FUNERAL DIRECTOR W. M. COOK - BROOKS TOWSON		ADDRESS 1050 YORK RD TOWSON, MD 21204	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 66 00699				
BIRTH NO. 66 00699					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) FLORENCE SMITH					2. DATE AND HOUR OF DEATH JANUARY 19, 1966 3:45 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL					A. STATE MARYLAND B. COUNTY 20-01				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				
					D. STREET ADDRESS (If rural, give location) 1922 W. FAYETTE ST.				
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH Approx 1981?	9. AGE (In years last birthday) 85	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME JAMES TURNER					14. MOTHER'S MAIDEN NAME MARY TURNER				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Medical Care Chart				
18. 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cerebral Thrombosis DUE TO (B) Generalized Arteriosclerosis DUE TO ~ 40 yrs (C) _____ INTERVAL BETWEEN ONSET AND DEATH 3 days									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (H) (this hospital) attended the deceased from January 17, 1966 to January 19, 1966 , that (H) (we) lost saw the deceased alive on January 19, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Arthur W. Traum					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED January 19, 1966	
23C. PHYSICIAN'S NAME (Type) Arthur W. Traum					23D. ADDRESS M.D. University Hospital, Baltimore Md				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1/21/66		24C. NAME of CEMETERY or CREMATORY Mt Auburn		24D. LOCATION (City, town, or county) (State) Baltimore Md			
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1966			25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR Martha P. [Signature]			ADDRESS 638 N. [Signature]	

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BALTIMORE CITY HEALTH DEPARTMENT			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 00700			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
BENJAMIN BROWN		January 20, 1966 10:30 A.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland	
1200 W. Mulberry Street		B. COUNTY 18-02	
		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
		Baltimore	
		D. STREET ADDRESS (If rural, give location)	
		1201 W. Mulberry Street	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH
Male	Negro	Wid	12-5-1888
9. AGE (In years last birthday)		10. CITIZEN OF WHAT COUNTRY?	
77		U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
R.E.T.			
11. FATHER'S NAME		12. MOTHER'S MAIDEN NAME	
UNK.		MAMIE BROWN	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		14. SOCIAL SECURITY NO.	
Yes WWI WWII			
15. INFORMANT		ADDRESS	
Dolores Brown		1201 W. Mulberry St.	
16. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Pulmonary emphysema OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
0			
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
No			
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Charles S. Petty, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE	
Burial		1-24-66	
23C. NAME of CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
Baldwin NAT.		Baltimore Md.	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR	
JAN 21 1968		E. Taylor, M.D.	
24C. FUNERAL DIRECTOR		ADDRESS	
Morton & Dyett F.H.		1701 Laurens	

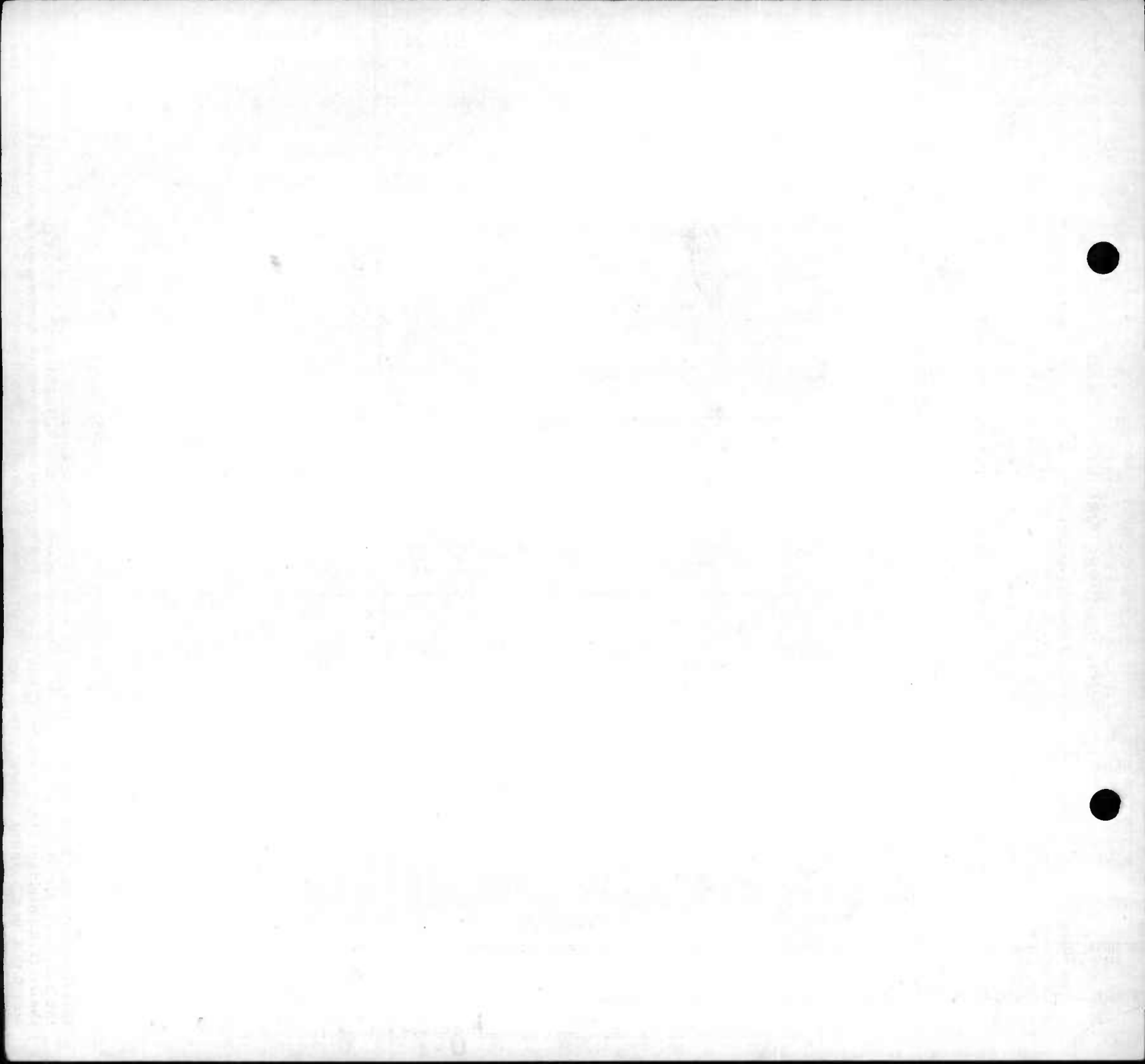
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MILITARY FORCE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

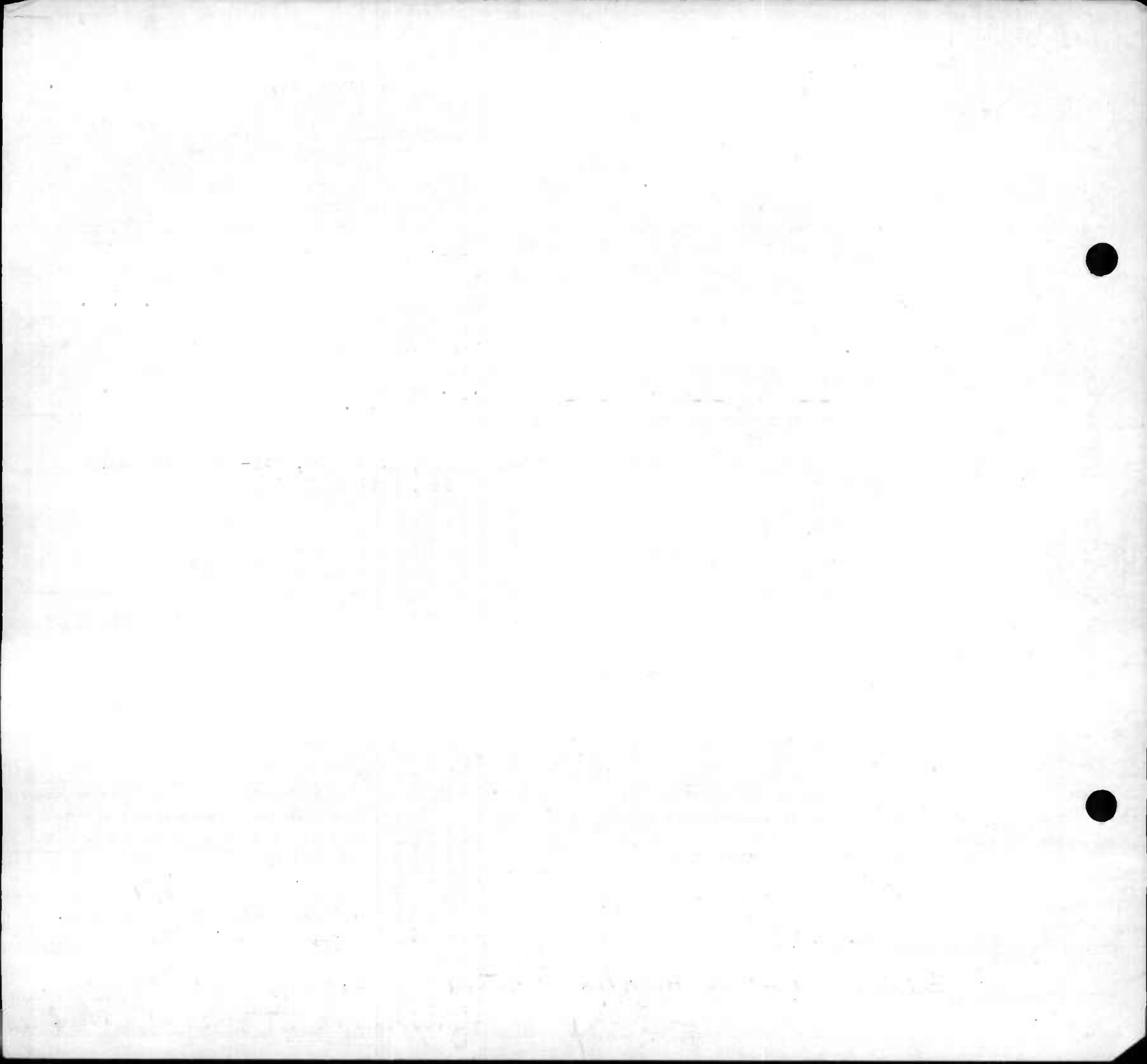
BIRTH NO. 66 00701		CITY HEALTH DEPARTMENT		Registered No. 66 00701	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARY BROWN		2. DATE AND HOUR OF DEATH JAN. 19 1966 5 10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 19-04		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE CITY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 MERCY HOSPITAL		D. STREET ADDRESS (If rural, give location) 604 S. FULTON AVE.		9. AGE (In years last birthday) 57	
5. SEX F	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8-25-1908	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) BALTIMORE MD.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MAHLON TURNER		14. MOTHER'S MAIDEN NAME SARAH WRIGHT		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO.		17. INFORMANT MONROE BROWN		ADDRESS 604 S. Fulton Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) DUE TO MYOCARDIAL INFARCT (B) DUE TO HYPERTENSIVE & ARTER- (C) 10 SCLEROTIC CARDIOVASC DISEASE		INTERVAL BETWEEN ONSET AND DEATH Approx. 1 day	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus, SIGMOID TUMOR		19A. DATE OF OPERATION 12-23-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED SIGMOID TUMOR	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from DEC 22 1965 to JAN 19 1966, that (I) (we) lost saw the deceased alive on JAN 19 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE Mary Jim Ratner MD M.D.		23B. DATE SIGNED JAN 19, 1966		23C. PHYSICIAN'S NAME (Type) M.D.	
23D. ADDRESS MERCY HOSP Box 98		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-22-66	
24C. NAME OF CEMETERY OR CREMATORY MT. Auburn		24D. LOCATION BALTO., Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 21 1966	
25B. NAME OF REGISTRAR Robert E. Sawyer		25C. FUNERAL DIRECTOR Margaret Dye F.H.		ADDRESS 1701 Laurens ST.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00702 M.E. CASE NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 00702	
1. NAME OF DECEASED (Type or Print) MILLNER, Harrison Greely			2. DATE AND HOUR OF DEATH January 10, 1966 10:50 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Pennsylvania B. COUNTY V-35 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Philadelphia D. STREET ADDRESS (If rural, give location) 2017 Rodman Street		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH 1-6-14	9. AGE (In years last birthday) 52	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Ship Yard		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Nelson C. Millner			14. MOTHER'S MAIDEN NAME Lucy Ann Broadnox		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1-3-44 to 9-6-45		16. SOCIAL SECURITY NO. 245-01-3393		17. INFORMANT Record ADDRESS V. A. Hospital, 3900 Loch Raven Blvd. Baltimore, Md. 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 002.1 I Tuberculosis, pulmonary, Far-advanced, active			INTERVAL BETWEEN ONSET AND DEATH 10 years		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 11/30/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Tuberculosis		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from January 8 19 65 to January 10 19 66 , that (X) (we) last saw the deceased alive on January 10 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Donald H. Hooker				23B. DATE SIGNED 1/17/66	
23C. PHYSICIAN'S NAME (Type) DONALD H. HOOKER			23D. ADDRESS VA Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-23-66		24C. NAME OF CEMETERY OR CREMATORY Hamlin Cemetery	
24D. LOCATION (City, town, or county) (State) Spray, North Carolina		25A. DATE REC'D BY HEALTH DEPT. JAN 21 1966			
25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Thyngton & Dyett Funeral Home 1701 Lawrence			



BIRTH NO. 6528412

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)*William*
ROBERT McCULLOUGH

2. DATE AND HOUR PRONOUNCED DEAD

January 20, 1966

10:25 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4308 Belmar Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

single

8. DATE OF BIRTH

Nov. 15, 1965

9. AGE (In years
last birthday)If Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.

2

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

John Robert McCullough

14. MOTHER'S MAIDEN NAME

Shirley Sanford

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Shirley A. Sanford

same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Interstitial Pneumonitis.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-20-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

burial

23B. DATE

1-22-66

23C. NAME of CEMETERY or CREMATORY

Woodlawn Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JAN 21 1966

Leonard J. Ruck Inc Baltimore, Md.

VALLEY FORGE

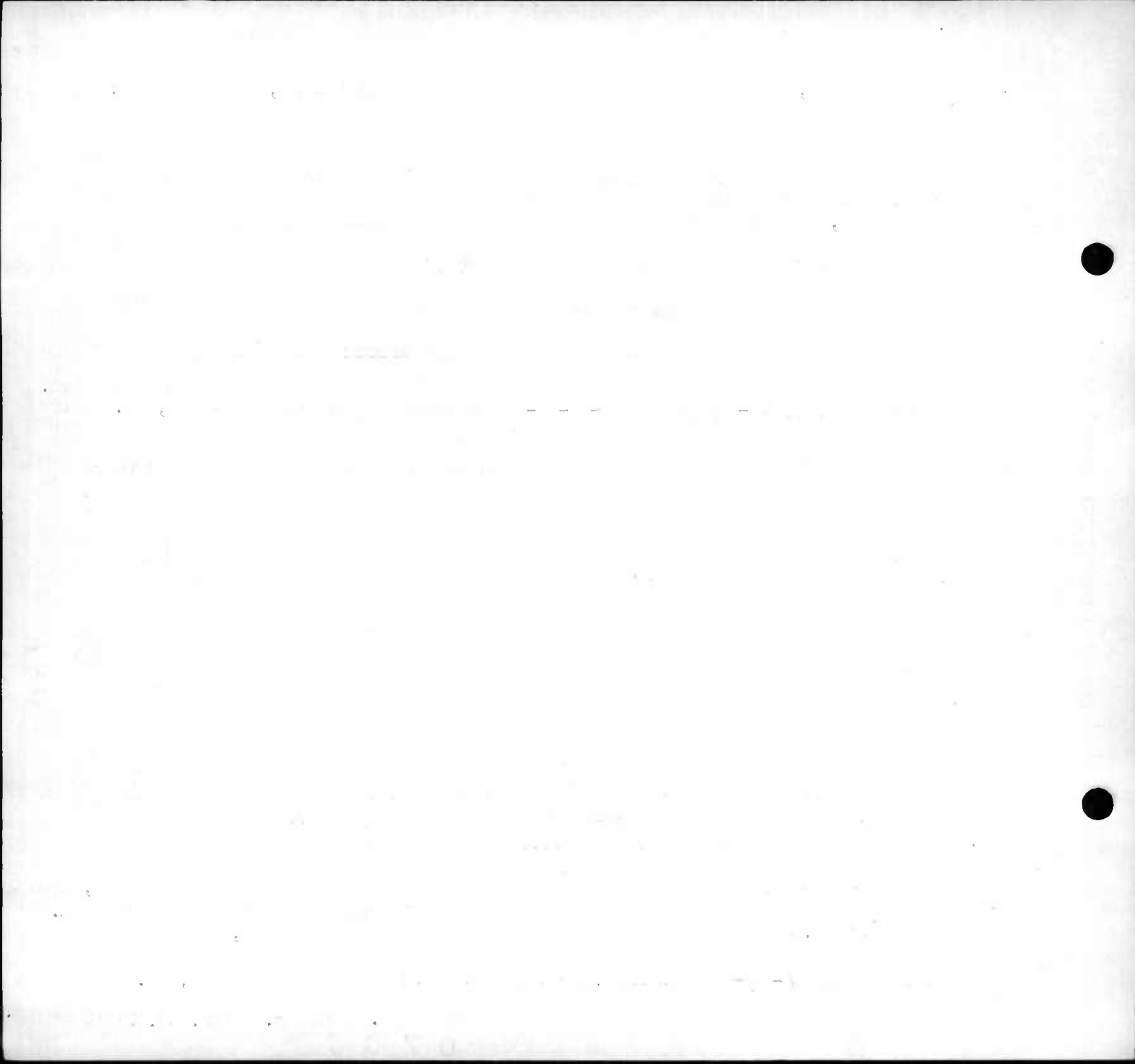
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1-55-7

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

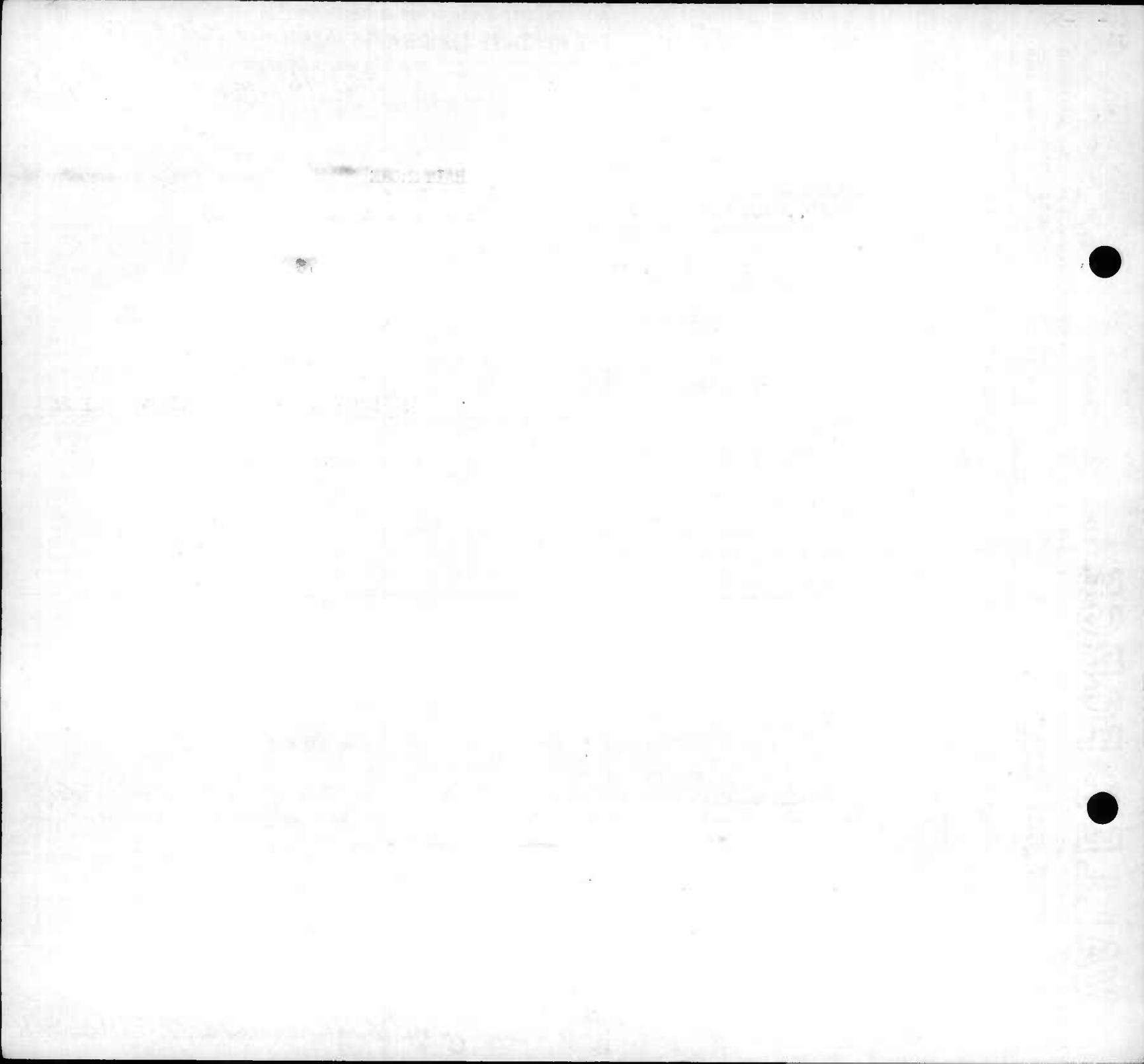
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00704	
66 00704				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) LOLLI, LORENZO		JANUARY 20, 1966 11:00 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL 3900 Loch Raven Boulevard Baltimore, Maryland 21218			A. STATE Maryland B. COUNTY 27-38		
5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #12		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer			D. STREET ADDRESS (If rural, give location) 5509 Hillen Road		
8. DATE OF BIRTH 8/7/95		9. AGE (In years last birthday) 70		11. BIRTHPLACE (State or foreign country) Italy	
10B. KIND OF BUSINESS OR INDUSTRY Construction		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Dominic Lolli	
14. MOTHER'S MAIDEN NAME Mary Signore De Signore		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 5/29/18 - 6/7/19		16. SOCIAL SECURITY NO. 213-05-94-87	
17. INFORMANT VA Hospital Records		ADDRESS 3900 Loch Raven Blvd. Baltimore, Md. 21218			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 162.1 I CAUSE OF DEATH (A) Bronchogenic Carcinoma of Lung DUE TO (B) _____ DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH 5 years			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that 11 (this hospital) attended the deceased from November 28th 19 65 to January 20th 19 66 , that 11 (we) lost saw the deceased alive on January 20th 19 66 and that in 11 (our) opinion death occurred on the date and hour and from the causes stated above. 11 (We) (did) (did not) view the body after death.					
23A. SIGNATURE William B. Joy				23B. DATE SIGNED January 20, 1966	
23C. PHYSICIAN'S NAME (Type) WILLIAM B. JOY		23D. ADDRESS VA Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) entombment		24B. DATE 1-24-66		24C. NAME OF CEMETERY OR CREMATORY Lorraine Park Mausoleum	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 21 1966			
25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

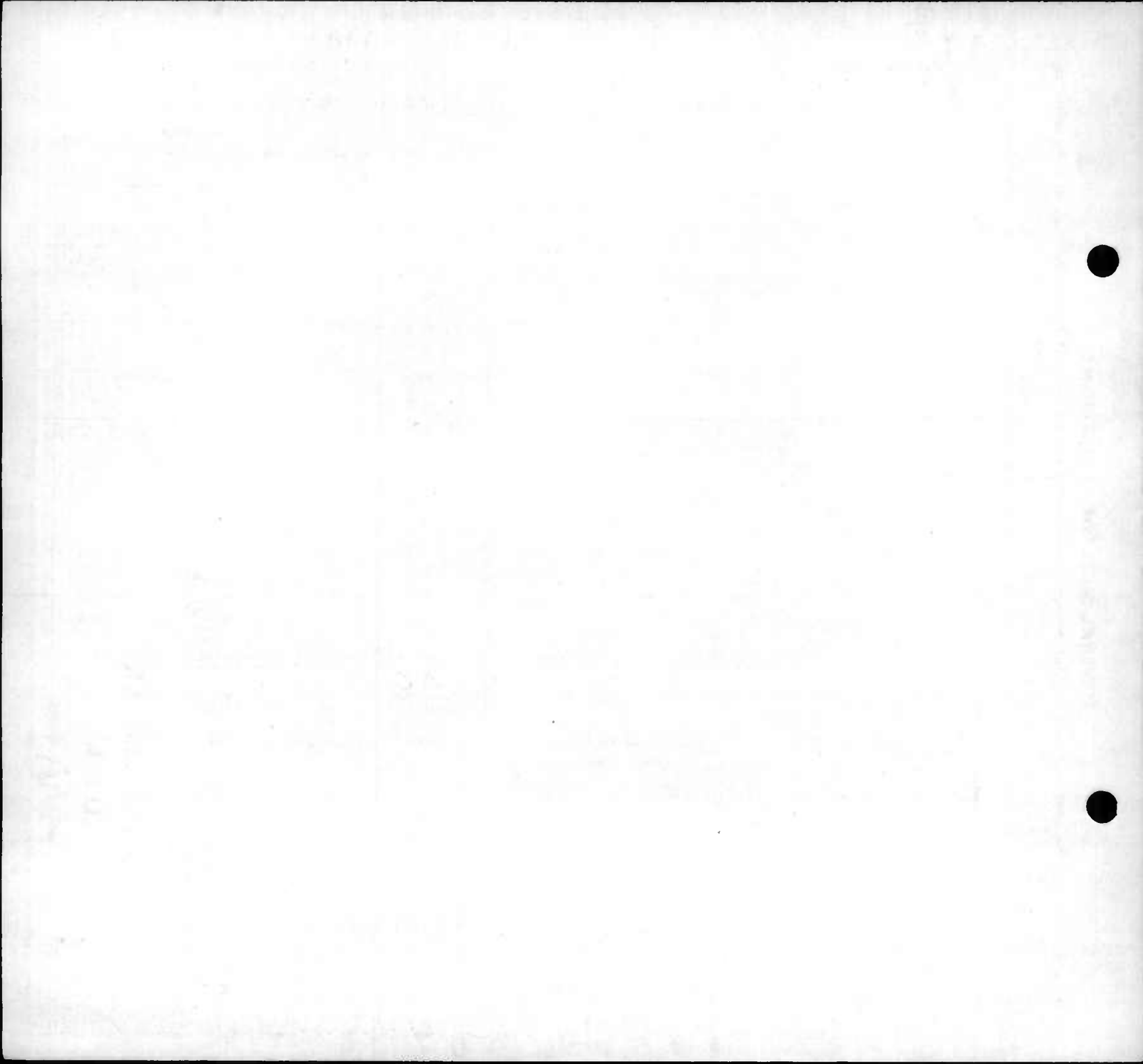
BIRTH NO. 5152 66 00705				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00705	
1. NAME OF DECEASED (Type or Print) SPENCER, AARON				2. DATE AND HOUR OF DEATH JAN 16, 1966 10 ⁴⁵ A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTO., MARYLAND 21224				A. STATE Md. B. COUNTY Baltimore			
5. SEX Male				6. RACE N		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) porter				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) AAB Ind	
13. FATHER'S NAME Greenway Spencer				14. MOTHER'S MAIDEN NAME Frances J. Johnson			
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
						RECORDS: BCH 4940 EASTERN AVENUE #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) PULMONARY TUBERCULOSIS				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 6 YRS.	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO		(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-3-1966 to 1-16-1966, that (I) (we) last saw the deceased alive on 1-16-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE W. Norris Horowitz		23B. DATE SIGNED 16 Jan 66	
23C. PHYSICIAN'S NAME (Type) DR NORRIS HOROWITZ				23D. ADDRESS M.D. 4940 EASTERN AVENUE #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan 20/66		24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery AAB Ind		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1966		25B. NAME OF REGISTRAR Robert E. [unclear]		25C. FUNERAL DIRECTOR [unclear]		ADDRESS 1701-3 N Bond St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 66 00706					CERTIFICATE OF DEATH					Registered No. 66 00706									
M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) <i>Fitzpatrick, Mary</i>					2. DATE AND HOUR OF DEATH <i>January 21, 1966 5:50 A.M.</i>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Mo.</i> 8. COUNTY <i>Baltimore</i>					CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>University Hospital</i>					D. STREET ADDRESS (If rural, give location) <i>6720 Park Ave #15</i>														
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>		8. DATE OF BIRTH <i>2/23/02</i>		9. AGE (In years last birthday) <i>63</i>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <i>?</i>									
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					13. FATHER'S NAME <i>?</i>					14. MOTHER'S MAIDEN NAME <i>?</i>									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>					16. SOCIAL SECURITY NO.					17. INFORMANT <i>Husband</i> ADDRESS <i>6720 Park Ave 15H</i>									
18. <i>605 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.										CAUSE OF DEATH (A) <i>Severe Dehydration</i> DUE TO <i>Bladder Calculi</i> (B) <i>Septicemia</i> DUE TO <i>Hemorrhagic cystitis pyelonephritis</i> (C)					INTERVAL BETWEEN ONSET AND DEATH <i>3 wks</i>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION <i>0</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <i>NO</i>									
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)									
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
21F. HOW DID INJURY OCCUR?					22. I certify that (I) (this hospital) attended the deceased from <i>January 19</i> 19 <i>66</i> to <i>January 21</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>January 21</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					23A. SIGNATURE <i>Ralph Gardener</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>									
23B. DATE SIGNED <i>1/21/66</i>					23C. PHYSICIAN'S NAME (Type) <i>RALPH GARDENER</i> M.D.					23D. ADDRESS <i>8002 St Paul St., Baltimore Md</i>									
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>					24B. DATE <i>10-25-66</i>					24C. NAME OF CEMETERY or CREMATORY <i>Holy Family</i>									
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>					25A. DATE REC'D BY HEALTH DEPT. <i>JAN 21 1966</i>					25B. NAME OF REGISTRAR <i>Rebecca E. Johnson</i>									
25C. FUNERAL DIRECTOR <i>Frank H. Howell, Pikesville Md</i>					25D. ADDRESS <i>Pikesville Md</i>														



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 66 00707					CERTIFICATE OF DEATH					Registered No. 66 00707				
1. NAME OF DECEASED (Type or Print) James Robert Wiley					2. DATE AND HOUR OF DEATH January 18, 1966 11:59 A.M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Pikesville 8, 5300				
D. STREET ADDRESS (If rural, give location) Timberlane, Park Heights														
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH Sept. 17, 1911		9. AGE (In years last birthday) 54 yrs.		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caretaker					10B. KIND OF BUSINESS OR INDUSTRY Mrs. Allen Wurtzburger Calvert Co., Md.					11. BIRTHPLACE (State or foreign country) Pikesville 8, Md.				
12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME Joseph Wiley					14. MOTHER'S MAIDEN NAME Cora Smith				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None					16. SOCIAL SECURITY NO. 220-22-8860					17. INFORMANT Mrs. Ella Grace Wiley, Timberlane, Park Heights				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Myocardial Infarction DUE TO Thrombosis? (B) X DUE TO (C) X										INTERVAL BETWEEN ONSET AND DEATH one hour				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										X				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. After a bout of ventricular fibrillation, was pronounced deceased by Dr. Banks at Sinai Hospital										one hour				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from 5/1/1964 to 1/18/1966 , that (I) (we) last saw the deceased alive on 12/13/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE Gerald N. Maggid					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 1/18/66						
23C. PHYSICIAN'S NAME (Type) Gerald N. Maggid					23D. ADDRESS Pikesville Medical Center Pikesville, Md.									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan. 21, 1966		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery			24D. LOCATION (City, town, or county) (State) Pikesville 8, Md.							
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1966			25B. NAME OF REGISTRAR Gerald N. Maggid			25C. FUNERAL DIRECTOR Frank R. Newell			ADDRESS Pikesville 8, Md.					

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X

X

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FUNERAL DIRECTOR: IMPORTANT

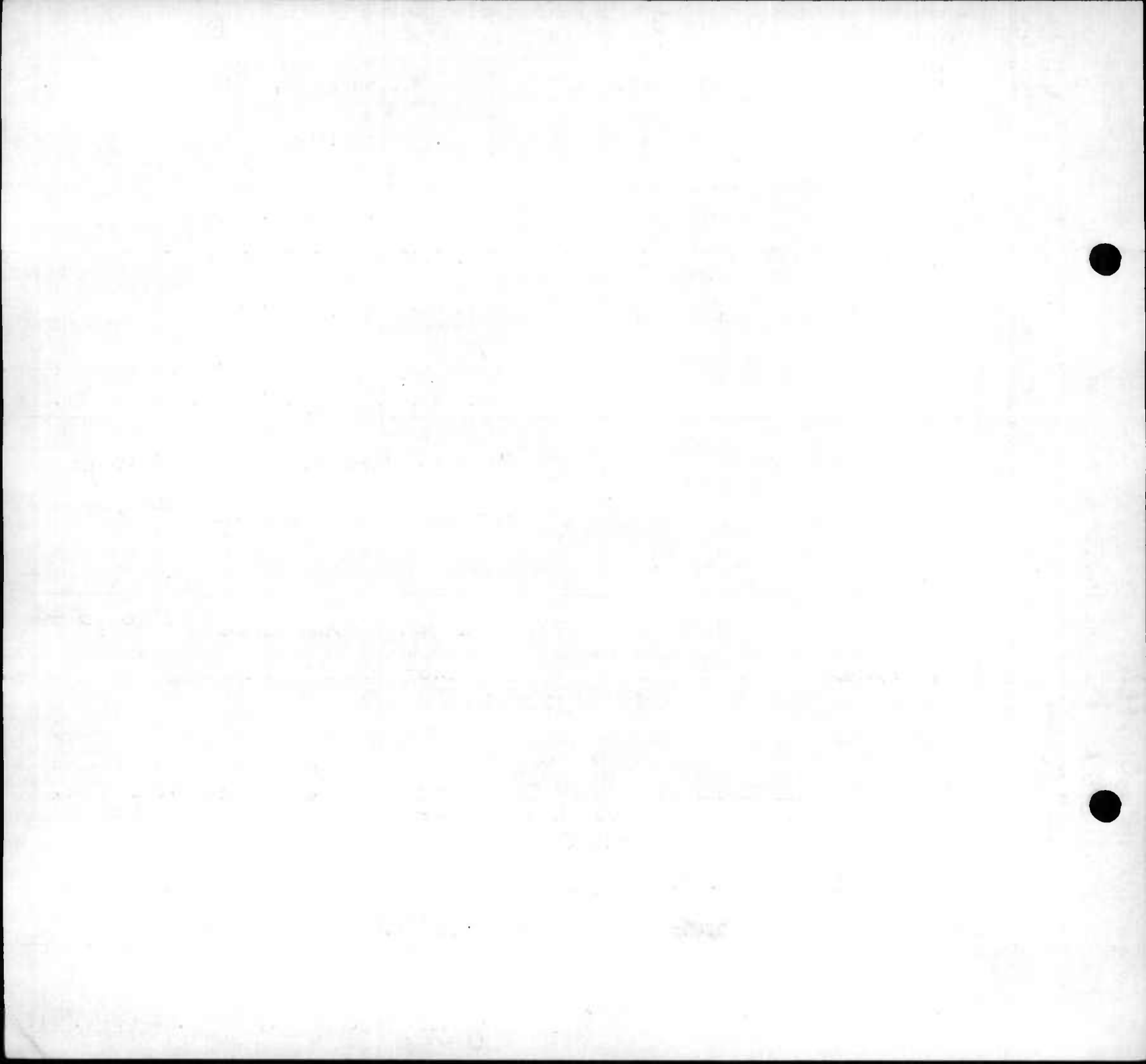
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH									
BIRTH NO. 66 00708		Registered No. 66 00708							
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Lillian Mary Stonisifer</i>				2. DATE AND HOUR OF DEATH <i>1-20-66</i> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>6512 Parr Ave. Balto 15-Sud</i>						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
D. STREET ADDRESS (If rural, give location) <i>6512 Parr Ave - Balto 15 Sud</i>						28-31			
5. SEX <i>Female</i>		6. RACE <i>White</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>		8. DATE OF BIRTH <i>6/10/1892</i>		9. AGE (In years last birthday) <i>73 4/100</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Oberlin Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		
13. FATHER'S NAME <i>William C. Carback</i>						14. MOTHER'S MAIDEN NAME <i>Mary Corrigan</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>21201-1300</i>		17. INFORMANT <i>Vernon P. Stonisifer</i>		ADDRESS <i>same</i>	
18. <i>75-7-31</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH (A) <i>TERMINAL UREMIA</i> DUE TO (B) <i>CHRONIC CONGESTIVE FAILURE</i> DUE TO (C) <i>HORSESHOE KIDNEY</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>ARTEROSCLEROTIC HEART DISEASE</i>									
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>4-7 1952</i> to <i>1-17 1966</i> , that (I) (we) last saw the deceased alive on <i>1-17 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.									
23A. SIGNATURE <i>Samuel P. Scalia</i>						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>1-21-66</i>	
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS M.D. <i>2 SHERWOOD AVE. PIKESVILLE, MD.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/25/66</i>		24C. NAME of CEMETERY or CREMATORY <i>Woodlawn</i>		24D. LOCATION (City, town, or county) (State) <i>Pikesville, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 21 1966</i>		25B. NAME OF REGISTRAR <i>Edgar E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Frank H. Powell, Pikesville</i>				ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00709				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 00709	
1. NAME OF DECEASED (Type or Print) EMMA JULIA SILLIK				2. DATE AND HOUR OF DEATH January 20, 1966 8 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Haven Nursing Home 3939 Penhurst Avenue				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Gork Road D. STREET ADDRESS (If rural, give location) Towson, Md.					
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH Jan. 29, 1880		9. AGE (in years last birthday) 85		If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Stephens City, Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Albert Bush				14. MOTHER'S MAIDEN NAME Campbell					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. NONE		17. INFORMANT: Son Mr. Geo. E. Sillik, Jr.			ADDRESS City. 1516 S. Charles St.,	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Central thrombosis				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH 10 days 20 yrs -	
19A. DATE OF OPERATION none				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from 1946 to 20 Aug 1966 , that (I) (we) last saw the deceased alive on 10 January 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.									
23A. SIGNATURE Conrad Acton						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Jan. 20, 1966	
23C. PHYSICIAN'S NAME (Type) CONRAD ACTON				23D. ADDRESS M.D. 1208 St. Paul Street, Baltimore					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/22/66		24C. NAME OF CEMETERY or CREMATORY Prospect Hill Cemetery			24D. LOCATION (City, town, or county) (State) Towson, Maryland		
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1966				25B. NAME OF REGISTRAR Robert E. Sillik		25C. FUNERAL DIRECTOR Stewart & Mowen Co., 108 W. North Av., City			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ALFRED J. MCKAY, Jr.

2. DATE AND HOUR PRONOUNCED DEAD

January 19, 1966 2:40 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

900 Cator Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

900 Cator Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

Sept. 6, 1903

9. AGE (In years
last birthday)

60 62

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Civil Engineer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore City

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Alfred J. McKay (Sr)

14. MOTHER'S MAIDEN NAME

Virginia Cook

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.17. INFORMANT: Sister Route 1 Box 239 A
Mrs. Geo. Washington, Woodford, Virginia

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Diabetes mellitus
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Chronic alcoholism

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-19-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1-21, 1966

23C. NAME OF CEMETERY or CREMATORY

Prospect Hill Cemetery Front Royal, Virginia

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

JAN 21 1966

24B. NAME OF REGISTRAR

Robert E. Bailey, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Stewart & Mowen Co., 108 W. North Av., City

WALLLEY HOUSE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00711				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 00711	
1. NAME OF DECEASED (Type or Print) HERWIG, John Jr				2. DATE AND HOUR OF DEATH 1.20.66-3⁴⁵ AM					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 27-09					
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital 33rd and Calvert Sts, Baltimore 18				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE					
				D. STREET ADDRESS (If rural, give location) 1702 Harborside Rd, B					
5. SEX M	6. RACE W	7. MARRIED-NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 5.23.24	9. AGE (In years last birthday) 41	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10B. KIND OF BUSINESS OR INDUSTRY Salesman -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Herwig				14. MOTHER'S MAIDEN NAME Myrtle O'Connor					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes W2				16. SOCIAL SECURITY NO. 216-20-4528		17. INFORMANT WIFE ROSE HERWIG		ADDRESS as above 1702 Harborside Rd Baltimore	
18. 237X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Recurrent brain tumor 4 1/2 years				(A) DUE TO					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO RA					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO					
19A. DATE OF OPERATION 2 1962		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED gross		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) no		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -					
22. I certify that (I) (this hospital) attended the deceased from 1.7.1966 to 1.20.1966 , that (I) (we) last saw the deceased alive on 1.20.1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Danuta Daniec MD						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1.20.66	
23C. PHYSICIAN'S NAME (Type) DANUTA DANIEC				23D. ADDRESS M.D. UNION MEMORIAL HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan. 24/66		24C. NAME OF CEMETERY or CREMATORY Balto. Nat. Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1966		25B. NAME OF REGISTRAR Philip Herwig Sons		25C. FUNERAL DIRECTOR Philip Herwig Sons		ADDRESS 2024 Orleans St			

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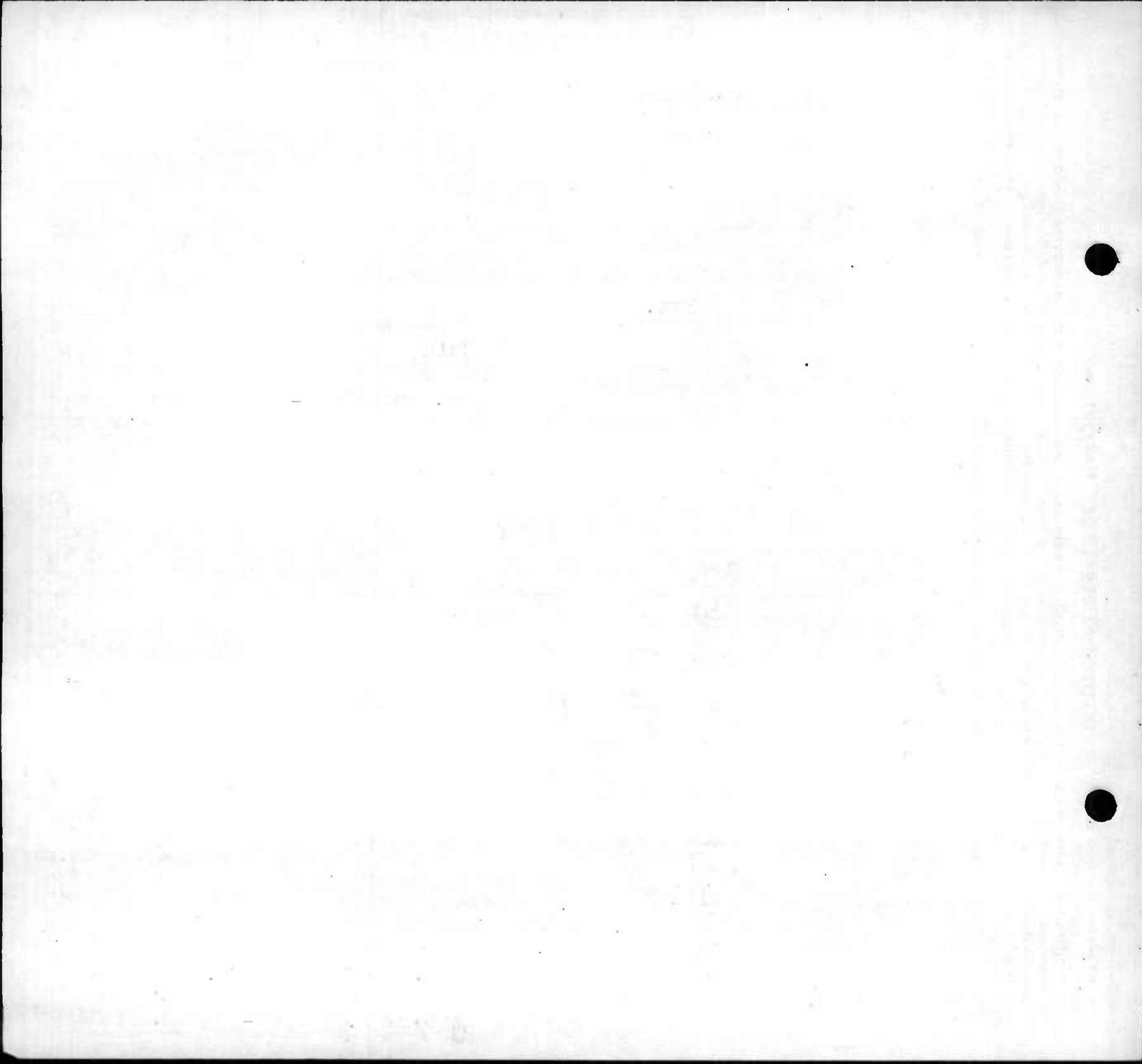
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

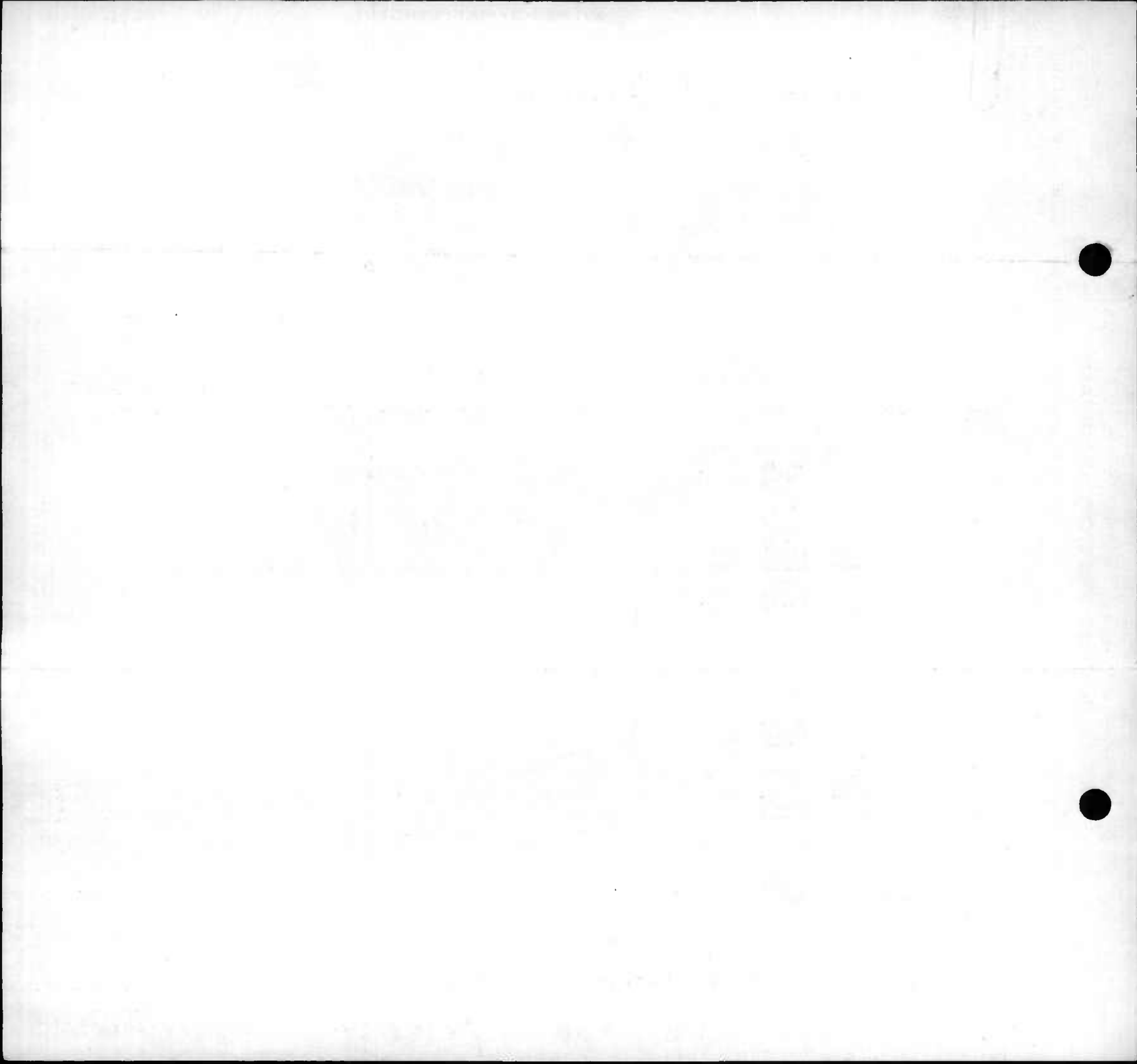
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH										Registered No. <u>66 00712</u>
BIRTH NO. <u>66 00712</u>		M.E. CASE NO.								
1. NAME OF DECEASED (Type or Print) <u>Walter J. Hodges</u>						2. DATE AND HOUR OF DEATH <u>20 Jan 66</u> <u>1 45</u> P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md</u> B. COUNTY <u>16-06</u>				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University of Maryland Hospital</u>						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>				
						D. STREET ADDRESS (If rural, give location) <u>827 Franklin town Rd.</u>				
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u>		8. DATE OF BIRTH <u>28 May 98</u>	9. AGE (In years last birthday) <u>67</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardner</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Ret. Family</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Joseph N. Hodges</u>						14. MOTHER'S MAIDEN NAME <u>Sula Burns</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Mrs. Sula Dean-2914 Presstman St</u>				
18. <u>204.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Gastrointestinal Hemorrhage</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Chronic myelogenous leukemia</u>						CAUSE OF DEATH (A) <u>Gastrointestinal Hemorrhage</u> DUE TO (B) <u>Chronic myelogenous leukemia</u> DUE TO (C) <u>Obstructive jaundice and surgery</u>				
INTERVAL BETWEEN ONSET AND DEATH <u>9 1/2 hrs.</u> <u>7 mo</u>										
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Obstructive jaundice and surgery</u>										
19A. DATE OF OPERATION <u>18 Jan 66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Obstructive jaundice</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>N/A</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>N/A</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>N/A</u>						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>N/A</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <u>N/A</u>		21F. HOW DID INJURY OCCUR? <u>N/A</u>						
22. I certify that (I) (this hospital) attended the deceased from <u>18 Jan</u> 19 <u>66</u> to <u>20 Jan</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>20 Jan</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
23A. SIGNATURE <u>Robert S. Holt, md</u>						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>20 Jan 66</u>		
23C. PHYSICIAN'S NAME (Type) <u>Robert S. Holt</u>				23D. ADDRESS M.D. <u>University Hospital, Baltimore, md</u>						
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/24/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Arbutus Memorial Pk.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Co. Maryland</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1966</u>		25B. NAME OF REGISTRAR <u>Herbert E. Nutter</u>		25C. FUNERAL DIRECTOR <u>Herbert E. Nutter</u>		ADDRESS <u>3035 W. North Ave</u>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

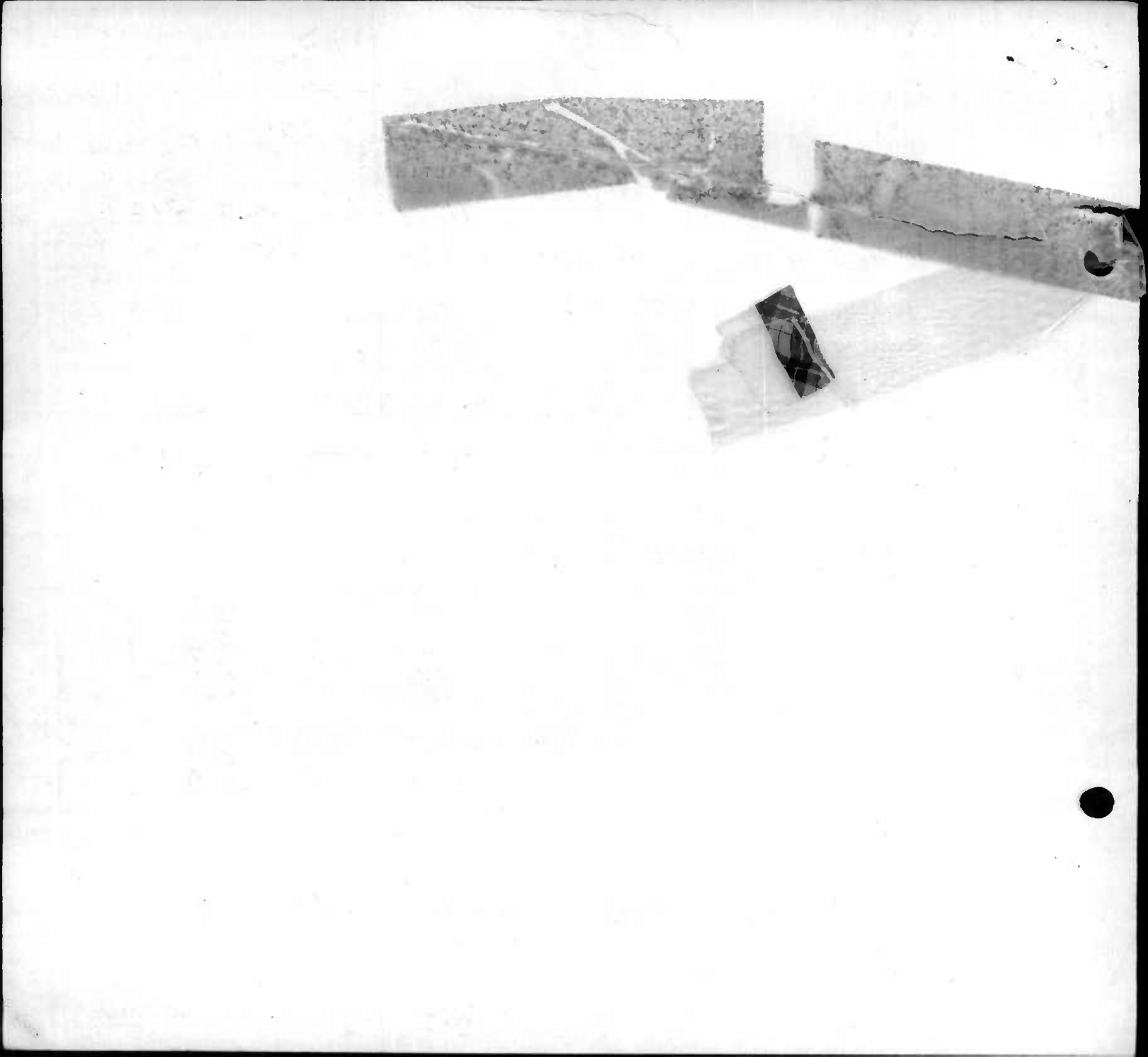
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00713	
BIRTH NO. 66 00713		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Linda GOTT (LINDIE V.)		2. DATE AND HOUR OF DEATH 1-13-66 10:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 3-01			
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME & HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 1617 E. BALTO. ST			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH MAY 19 1900	9. AGE (In years last birthday) 65	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME VINCENT GRAY		14. MOTHER'S MAIDEN NAME MARGARET KNOTT	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT ADDRESS HARRY GOTT BALTO., MD. 31	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HYPERNEPHROMA		CAUSE OF DEATH (A) HYPERNEPHROMA DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. METASTASIS TO THE LIVER,		(B) METASTASIS TO THE LIVER, DUE TO			
(C) LUNGS; MARKED DEHYDRATION					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-12-66 to 1-13-66 , that (I) (we) lost saw the deceased alive on 1-13-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ephraim B. Barzaga M.D.				23B. DATE SIGNED 1-13-66	
23C. PHYSICIAN'S NAME (Type) Ephraim B. BARZAGA		23D. ADDRESS CHURCH HOME & HOSP. BALTO.-31, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/17/66		24C. NAME OF CEMETERY or CREMATION WATERS MEM. CEMETERY ISLAND CREEK-CALVERT CO., MD.	
24D. LOCATION (City, town, or county) (State) MUTUAL 130X34		25A. DATE REC'D BY HEALTH DEPT. JAN 21 1966		25B. NAME OF REGISTRAR AD. HARKNESS	
25C. FUNERAL DIRECTOR AD. HARKNESS		25D. ADDRESS PORT REPUBLIC, MD.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH										Registered No. 66 00714	
BIRTH NO. M.E. CASE NO.		66 00714									
1. NAME OF DECEASED (Type or Print) <i>Henry Cohen</i>						2. DATE AND HOUR OF DEATH 1-19-66 12:15 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address as location) <i>Johns Hopkins Hosp.</i>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>11 Slade - apt 312</i>					
5. SEX <i>Male</i>		6. RACE <i>White</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>		8. DATE OF BIRTH <i>12/6/10</i>		9. AGE (In years last birthday) <i>55</i>		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>						10B. KIND OF BUSINESS OR INDUSTRY <i>Clothing Mfg.</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Samuel Cohen</i> JACOB						14. MOTHER'S MAIDEN NAME <i>SARAH MAROWITZ</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Mrs. Ruth Cohen 11 Slade Avenue Apt 312</i>					
18. <i>4-20-1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH (A) <i>Cardiac arrhythmia</i> DUE TO (B) <i>Acute Myocardial Infarction</i> DUE TO (C) <i>Arteriosclerotic Cardiovascular disease ? 9 yrs.</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i> <i>1+5 hours</i> <i>? 9 yrs.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <i>0</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 19 1966</i> to <i>Jan 19 1966</i> , that (I) (we) last saw the deceased alive on <i>Jan 19 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>Martin S. Fergenson</i>								M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>Jan 19 1966</i>	
23C. PHYSICIAN'S NAME (Type) <i>MARTIN S. FERGENSON</i>								23D. ADDRESS <i>Johns Hopkins Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>Jan 20/66</i>		24C. NAME of CEMETERY or CREMATORY <i>Adath Jeshurun</i>				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 21 1966</i>				25B. NAME OF REGISTRAR <i>Sgt. Levinson</i>				25C. FUNERAL DIRECTOR ADDRESS <i>& Bros Inc. 6010 Reisterstown Road</i>			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

NATHAN

PRAGER

2. DATE AND HOUR PRONOUNCED DEAD

January 19, 1966

1:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Sinai Hospital of Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4144 Fallstaff Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married

8. DATE OF BIRTH

February 5, 1889

9. AGE (In years
last birthday)

76

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Supplies

10B. KIND OF BUSINESS OR INDUSTRY

Tailoring industry

11. BIRTHPLACE (State or foreign country)

German

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Aron Prager

14. MOTHER'S MAIDEN NAME

Regina Spier

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

075-12-0833

17. INFORMANT

ADDRESS

Mrs. Irma Prager, 4144 Fallstaff Road

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Septicemia (Gram Negative Bacteria)
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Pneumonitis
DUE TO

(C) Fracture of Neck of Right Femur.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.Carcinoma of colon with lung and liver
metastases.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

1/10/66

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED
Pinning of fracture

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Nursing Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Manor Nursing Home, Baltimore

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

1 5 '66

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Fell out of bed.

22.

I certify that I held an Inquiry ☒ Inspection ☐ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/20/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1/20/1966

23C. NAME OF CEMETERY or CREMATORY

Chevra Ahavas Chesed Inc.

23D. LOCATION

(City, town, or county)

(State)

Randallstown, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JAN 21 1966

24B. NAME OF REGISTRAR

Robert E. Farkley, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

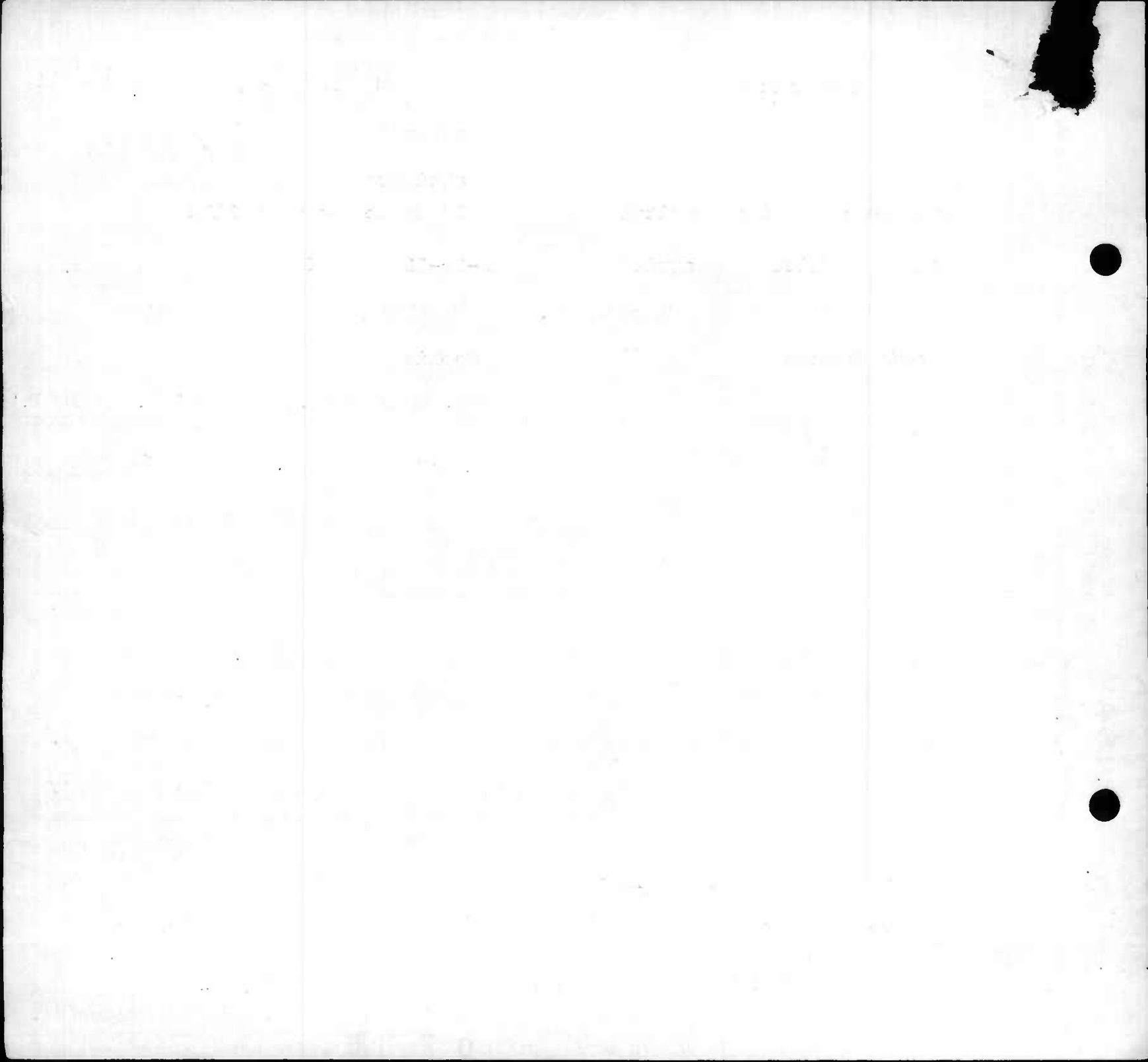
Sol Levinson & Bros. 6010 Reisterstown Rd.

WALLLEY FORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, or by the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

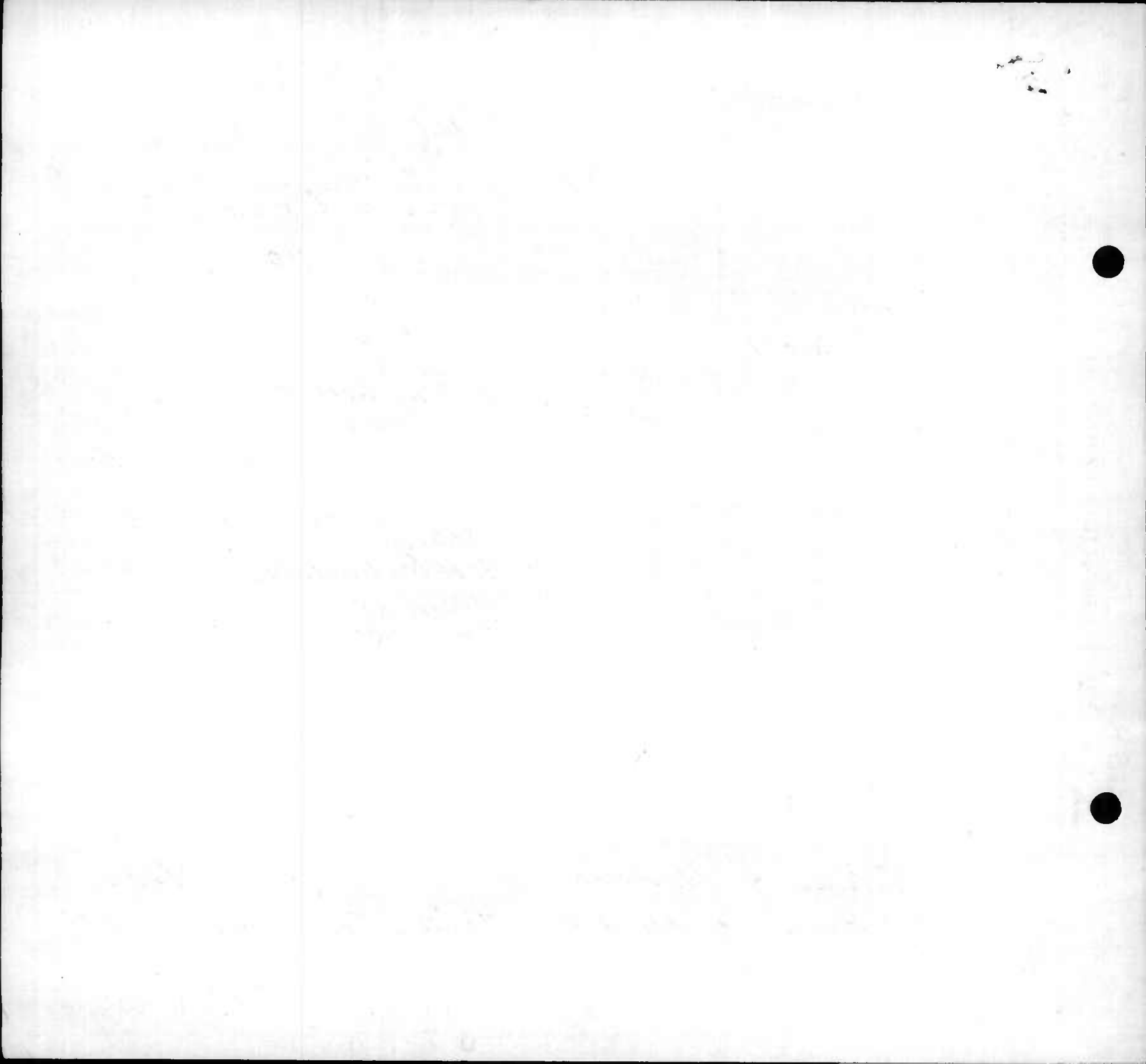
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <u>66 00716</u>				
BIRTH NO. <u>66 00716</u>									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <u>Leon Carton</u>					2. DATE AND HOUR OF DEATH <u>1/20/66</u> <u>1840</u> <u>AM.</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>The Johns Hopkins Hospital</u>					A. STATE <u>Maryland</u> B. COUNTY <u>Balto</u>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>				
					D. STREET ADDRESS (If rural, give location) <u>Old Court Road Box 317C</u>				
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>5-20-22</u>	9. AGE (In years last birthday) <u>43</u>	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Executive</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Furniture Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David Carton</u>					14. MOTHER'S MAIDEN NAME <u>Sophie ?</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>214-14-0823</u>		17. INFORMANT <u>Mrs. Muriel Carton</u>				
					ADDRESS <u>Old Court Rd. Box 317 C.</u>				
18. <u>190.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <u>Cerebrovascular accident</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>malignant melanoma 2 years</u>									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>1/20/66</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>1/20</u> <u>1966</u> to <u>1/20</u> <u>1966</u> , that (I) (we) lost saw the deceased alive on <u>1/20</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>James Louie</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stork Phys. <input type="checkbox"/>			23B. DATE SIGNED <u>1/20/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>James Louie</u>					23D. ADDRESS <u>JOHNS HOPKINS HOSP</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>1/21/1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>Chizuk Emuno Cemetery</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1966</u>			25B. NAME OF REGISTRAR <u>Paul E. Farley</u>			25C. FUNERAL DIRECTOR ADDRESS <u>Sol Levinson & Bros. 6010 Reisterstown Rd.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 66 00717				
BIRTH NO. 66 00717					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <u>Wall Joseph</u>					2. DATE AND HOUR OF DEATH <u>1/19/66</u> <u>7:20 P.M.</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Franklin Square Hosp.</u>					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>19-02</u>				
5. SEX <u>Male</u> 6. RACE <u>White</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>					8. DATE OF BIRTH <u>70</u> 9. AGE (In years last birthday) <u>70</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocery</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Retail</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wall</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>219-32-1325</u>		17. INFORMANT <u>DR. George Wall</u> ADDRESS <u>Balt. 5917 Simmonds Ave. Md.</u>				
18. <u>331 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
					(A) <u>Bronchopneumonia</u>			<u>3 days</u>	
					(B) <u>Gen. cerebral Arterio-sclerosis</u>			<u>6 mos.</u>	
					(C) <u>Corbrovascular</u>			<u>4 months</u>	
19A. DATE OF OPERATION <u>0</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>1/14/66</u> 19 to <u>1/19/66</u> 19, that (I) (we) last saw the deceased alive on <u>1/19/66</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Silvino B. Mureses</u> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <u>1/19/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Silvino B. Mureses</u> M.D.					23D. ADDRESS <u>Franklin Square Hosp. Balt. Md.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>1/21/66</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Workmens Circle</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1966</u>			25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS INC. 6010 Reist Rd</u> ADDRESS				



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
66 00718		CERTIFICATE OF DEATH		66 00718	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Sherman CHARLES LAYTON		JAN. 20 1966 2 45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Md. —		4-01	
MERCY HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE 21202	
		D. STREET ADDRESS (If rural, give location)		16 MARKET PLACE	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
MALE	CAUCASIAN	Divorced	10-27-1896	69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
?	?	PENNSYLVANIA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
JAMES LAYTON		MARY ELLA HUGGINS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		None		The Mercy Hospital Records	
18. 584X17581.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) BILE PERITONITIS		several days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) PERFORATION DUODENUM		" "	
II		(C) CHOLELITHIASIS + STONE IN DUCT (COMMON BILE)		3 weeks	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		ARTERIOSCLEROTIC CARDIOVASC DISEASE, LAENNEC'S CIRRHOSIS		years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
JAN 19 '66		DUODENAL PERFORATION			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from DEC 30 1965 to JAN 20 1966, that (I) (we) last saw the deceased alive on JAN 20 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Mary Jane Ratner M.D.				JAN 20 1966	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		M.D. MERCY HOSPITAL Box 98			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Removal		1/21/1966		Crown Hill Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 21 1966		Robert E. Taylor		Wm. J. Johnson & Sons Baltimore, Md.	
25D. ADDRESS		25E. ADDRESS			
		Baltimore, Md.			

MERCY HOSPITAL
MALE CALCUHAN

JAMES LAYTON

MARY ELLA HUSKINS
PENNSYLVANIA
10-11-1902
16 MARKET PLACE
BATHING
MO

BILE PERITONITIS

PERFORATION DUODENUM

CHOLELITHIASIS + STONE
IN DUCT (COMMON BILE)
ANTERIOR CARDIAC
DISBASE, PERFECT CIRCULAT

JAN 19 1902 BILIAL PERFORATION

JAN 30

Mary Ann Patterson

DEC 30 JAN 20

X

MERCY HOSPITAL Bx 10

38-23-14

FR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.

66 00719

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

66 00719

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Yikes. Kucian

2. DATE AND HOUR OF DEATH

1/22/66

5 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

103 Scott Street 21201

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Separated

8. DATE OF BIRTH

8-31-16

9. AGE (In years
last birthday)

49

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Truck Driver

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Robert Giles

14. MOTHER'S MAIDEN NAME

Nora Durrth

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

unknown

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 Eastern Avenue 21224

1B.

141.9 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osthenio, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION lost.

CAUSE OF DEATH

(A) DUE TO

Metastatic Squamous Cell
CARCINOMA of the Tongue

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

3 1/2 months

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (natively medical examined)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10/27/65 19 to 1/22/66 19
that (I) (we) lost saw the deceased alive on 1/22/66 19 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

J. Hernandez

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

1/22/66

23C. PHYSICIAN'S
NAME (Type)

J. Hernandez

M.D.

23D. ADDRESS

City Hospitals 4940 Eastern Ave.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

24B. DATE

1/24/66

24C. NAME OF CEMETERY or CREMATORY

Oak Hill Ceme.

24D. LOCATION (City, town, or county) (State)

Marshall Virginia

25A. DATE REC'D BY HEALTH DEPT.

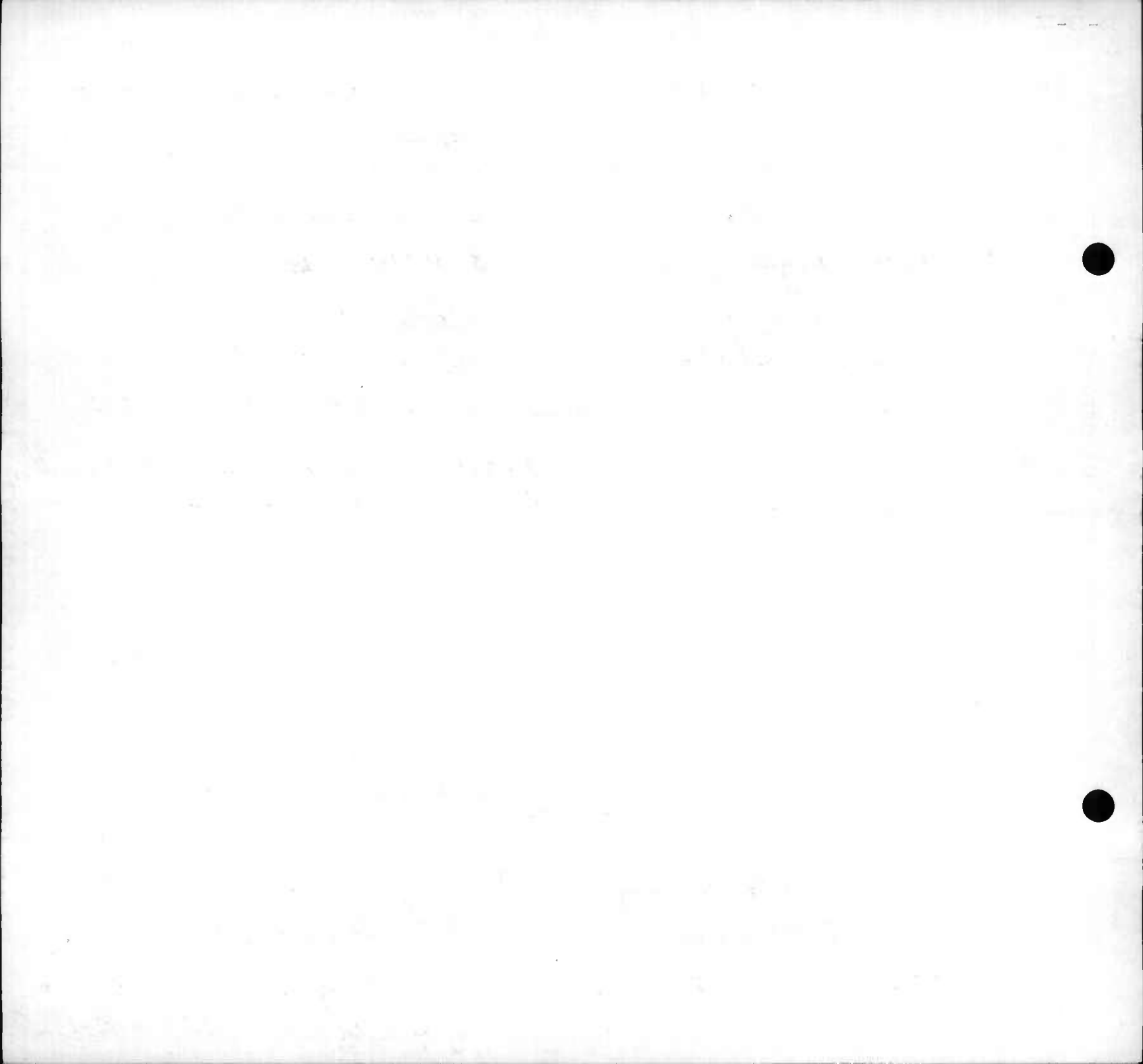
JAN 24 1966

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Gib. Gidman 1827 W. North Ave.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 00720	
BIRTH NO. 66 00720				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) GWYNN, AMY C.				2. DATE AND HOUR OF DEATH 1-20-66 7:45 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSP. OF MARYLAND				A. STATE MARYLAND B. COUNTY 15-48			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 3413 GWYNNAIS FALLS PKWY			
5. SEX FEMALE	6. RACE COLORED	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 3-28-85	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Harford County Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James Cohen			14. MOTHER'S MAIDEN NAME Rosa Franklin				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT AMY WALLEY (DAUGHTER)		ADDRESS SAME
18. 493 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) pneumonia, Sencu			
ANTECEDENT CAUSES				(B) dehydration			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1-14 19 66 to 1-20 19 66 , that (I) (we) lost saw the deceased alive on 1-20 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dahlia Luyeda M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-20-66	
23C. PHYSICIAN'S NAME (Type) DR. BENJAMIN BERDANU M.D.				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-24-66		24C. NAME OF CEMETERY or CREMATORY Mt. Zion Cemetery		24D. LOCATION (City, town, or county) (State) Long Green, Md. Balto. Co.	
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR L. T. Johnson		ADDRESS 2707 Ruscombe Lane	

FUNERAL DIRECTOR: IMPORTANT

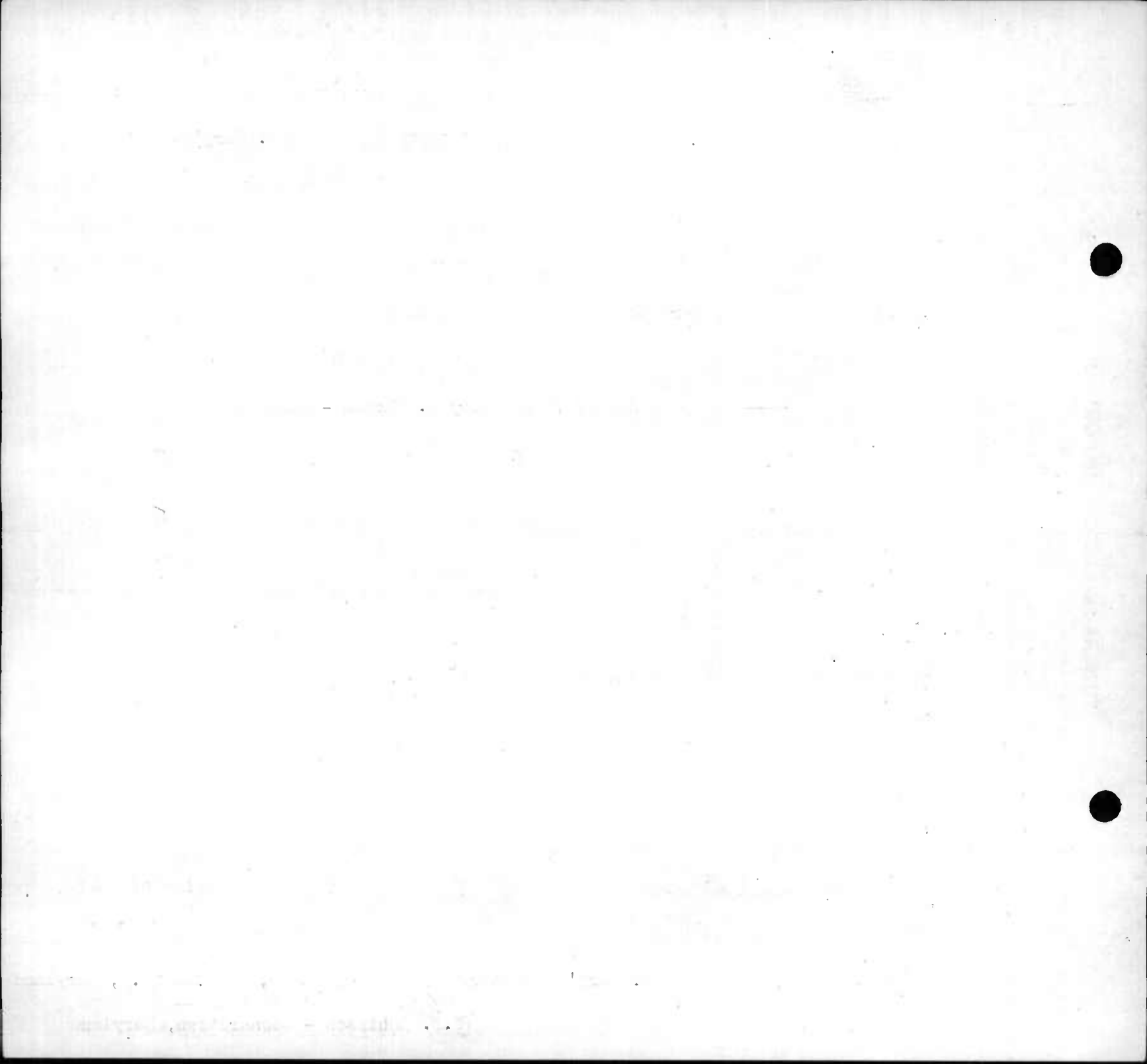
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00721		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00721	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ALTHA VIOLA HAMER			2. DATE AND HOUR OF DEATH JANUARY 20, 1966 12:30 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND. B. COUNTY 20-02		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 28 GORMAN AVE			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 28 GORMAN AVE		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH Oct. 5, 1895	9. AGE (In years last birthday) 70	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME James E. Logan			14. MOTHER'S MAIDEN NAME DELLA D.D. SLIVER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE		16. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS James E. Hamer Route 4 Box 361A. Pasadena, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 1551X-260X Metastatic Carcinoma			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.			(A) DUE TO Ca of the Gall Bladder (B) DUE TO and liver, & bladder (C) metastasis		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from February 15, 1962 to January 18, 1966, that (I) (we) last saw the deceased alive on January 20, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. at 12:30 P.M.					
23A. SIGNATURE Albinor Klimas M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) ALBINAS KLIMAS M.D.				23D. ADDRESS 2030 Wilkens Ave Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-24-66		24C. NAME of CEMETERY or CREMATORY GARDENS of Faith	
24D. LOCATION (City, town, or county) (State) BALTO CTY, MD.					
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Geo. L. Schaub FUNERAL HOME 2101 Frederick Ave.	

FUNERAL DIRECTOR: IMPORTANT

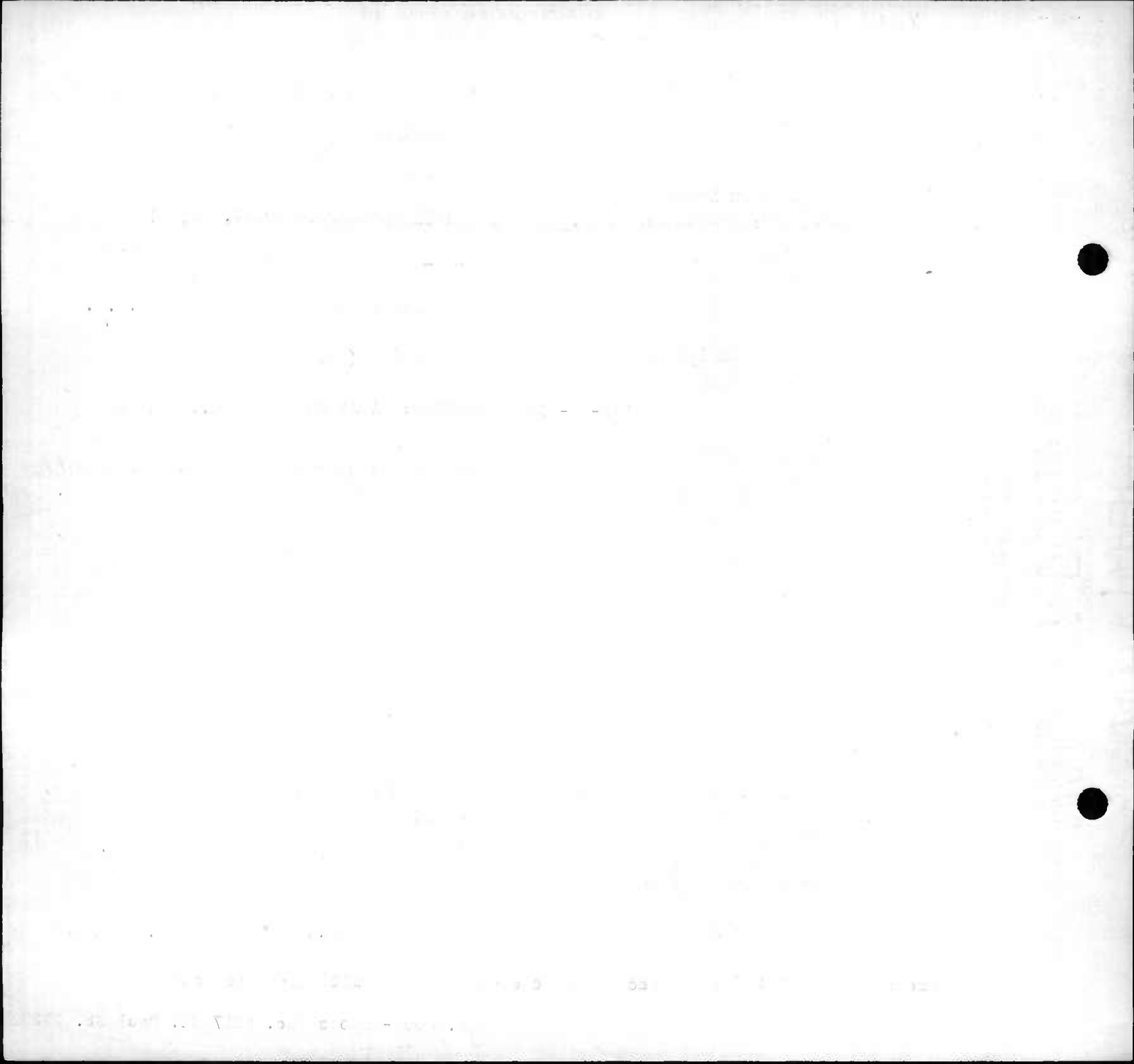
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00722	
BIRTH NO. 66 00722				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Joseph Thomas			2. DATE AND HOUR OF DEATH 1-19-66 8:45 a.m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY St. Mary's C. CITY OR TOWN (If outside city limits, write RURAL and give township) Charlotte Hall D. STREET ADDRESS (If rural, give location) 66-00		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4-3-91	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10B. KIND OF BUSINESS OR INDUSTRY farm tenant	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Jerry Thomas			14. MOTHER'S MAIDEN NAME Rose Ella Craig		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213 42 7062	17. INFORMANT Mary M. Thomas - same as # 4		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Peritonitis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Perforated Peptic Ulcer			INTERVAL BETWEEN ONSET AND DEATH 5 days 5 days		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 31-14-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Perf. gastric Ulcer		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/14 19 66 to 1/19 19 66 , that (I) (we) last saw the deceased alive on 1/19 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Don Eugene Detmer				23B. DATE SIGNED 1-19-66	
23C. PHYSICIAN'S NAME (Type) DON EUGENE DETMER				23D. ADDRESS JOHNS HOPKINS HOSP, BALTO, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/24/66		24C. NAME OF CEMETERY or CREMATORY St. Mary's Cemetery	
24D. LOCATION Bryantown, Charles Co., Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966			
25B. NAME OF REGISTRAR P.B. Robinson		25C. FULL NAME OF REGISTRAR P.B. Robinson - Leonardtown, Maryland			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

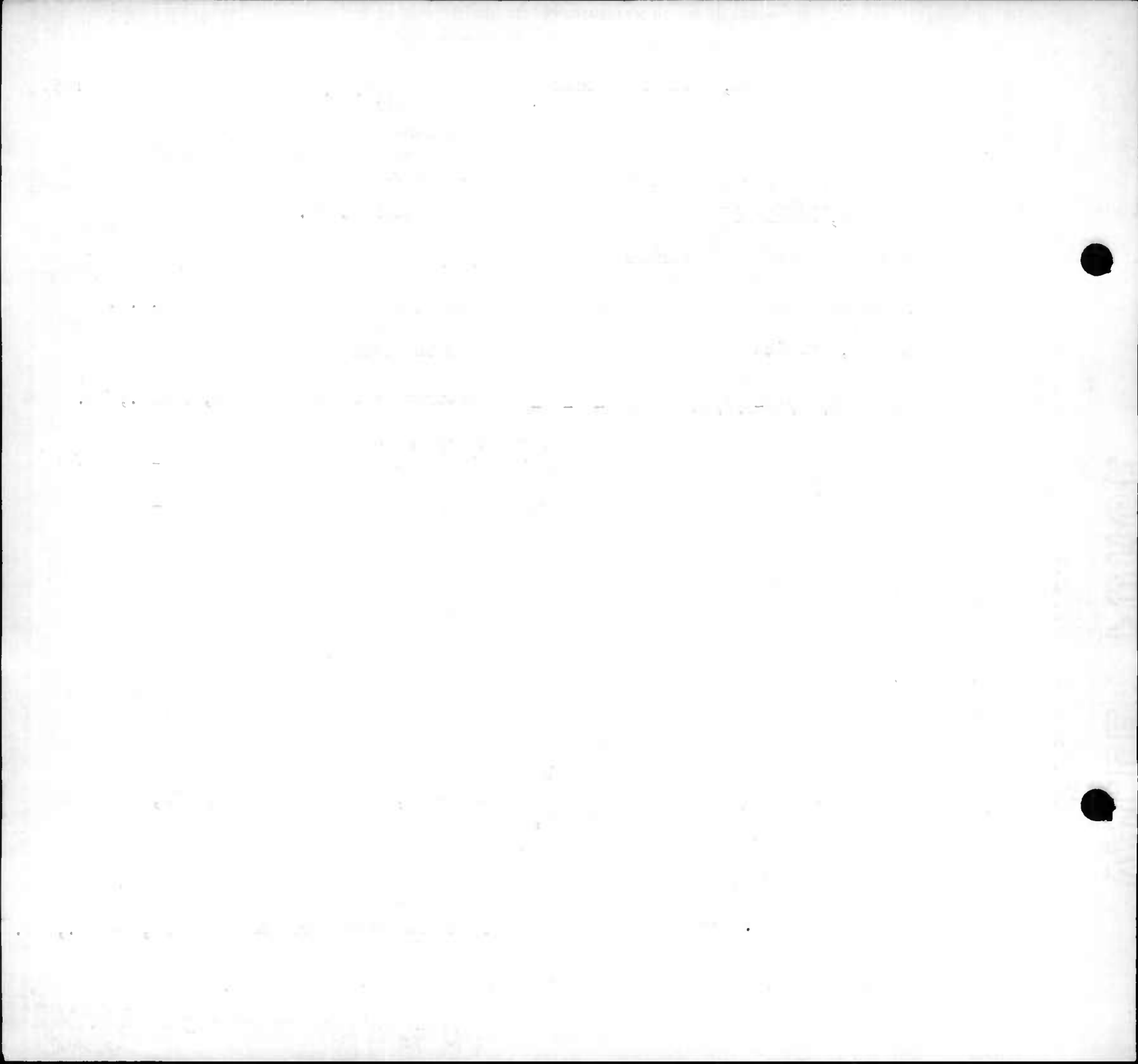
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00723	
BIRTH NO. K-500 66 00723		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Grace J. Kuhn		2. DATE AND HOUR OF DEATH 1-20-66 6:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland, #21224		A. STATE B. COUNTY Maryland			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 1025 Cathedral Street, #21201			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 9-10-00	9. AGE (In years last birthday) 65	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Adolph Jahn		14. MOTHER'S MAIDEN NAME Mamie (unK)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-09-1531		17. INFORMANT ADDRESS RECORDS: 4940 Eastern Ave., #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) 162.1 I CAUSE OF DEATH (A) DUE TO Bronchogenic Carcinoma 6 months		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-6-66 19 66 to 1-20 19 66, that (I) (we) last saw the deceased alive on 1-20 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Laurice McAfee M.D.				23B. DATE SIGNED 1-20-66	
23C. PHYSICIAN'S NAME (Type) LAURICE MCAFEE				23D. ADDRESS M.D. 4940 Eastern Ave., Baltimore, Md., #21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 1/21/66		24C. NAME OF CEMETERY or CREMATORY Greenmount Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR J. E. Farley		25C. FUNERAL DIRECTOR ADDRESS M. Cook-Brooks Inc. L217 St. Paul St. 21202	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00724	
BIRTH NO. 66 00724		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Runkles, William Charles		2. DATE AND HOUR OF DEATH 1/22/66 1:45A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 21-01			
FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital 3900 Loch Raven Blvd Baltimore, Maryland		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 509 Otterbine St.			
5. SEX Male	6. RACE Caucasian	7. MARRIED, NEVER MARRIED Married	8. DATE OF BIRTH 9/27/99	9. AGE (In years last birthday) 66	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mattress Stapler		10B. KIND OF BUSINESS OR INDUSTRY Factory		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William, Runkles		14. MOTHER'S MAIDEN NAME Edith Fogel	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 8/27/42-3/1/44		16. SOCIAL SECURITY NO. 214-03-50-00		17. INFORMANT ADDRESS Veterans Hospital Records, Balto., Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Bronchogenic carcinoma with generalized metastases		INTERVAL BETWEEN ONSET AND DEATH 6-10 Months			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Pulmonary congestion		5-6 Hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 10, 19 65 to January 22, 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on January 22, 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (We) (did) not view the body after death.					
23A. SIGNATURE <i>Anna R. Berky</i>				23B. DATE SIGNED 1/22/66	
23C. PHYSICIAN'S NAME (Type) Anna R. Berky				23D. ADDRESS Veterans Administration Hospital, Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/26/66		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.	
24D. LOCATION (City, town, or county) (State) 5501 Frederick Ave					
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR John J. Brown & Son Inc.	
				ADDRESS 25 Md.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED
(Type or Print)

MARY

FROMMELT

2. DATE AND HOUR PRONOUNCED DEAD

January 20, 1966

11:30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

107 Albemarle Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, give RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

107 Albemarle Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

1-21-97

9. AGE (In years
last birthday)

75 73

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

—

17. INFORMANT

Fred Frommelt

ADDRESS

Box 523 Pasadena Md

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive and Arteriosclerotic
Cardiovascular Disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
1/21/6623A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1-22-66

23C. NAME OF CEMETERY or CREMATORY

Glen Haven Cem

23D. LOCATION

(City, town, or county)

(State)

Glen Haven Md

24A. DATE REC'D BY HEALTH DEPT.

JAN 24 1966

24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

John J. Conner & Son Inc

ADDRESS

301 E 23rd St

WALLLEY FORT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 00726					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 66 00726				
1. NAME OF DECEASED (Type or Print) LONG DOROTHY IRENE					2. DATE AND HOUR OF DEATH 1-20-66 17⁰⁰ A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE md B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 6800 Highview Ave				
5. SEX F	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married		8. DATE OF BIRTH 5-25-14	9. AGE (In years last birthday) 51	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWF			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME HACKER FISHER					14. MOTHER'S MAIDEN NAME Florence Keisaber				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 178-05-5322		17. INFORMANT PT. & Husband				
18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular disease					CAUSE OF DEATH Arteriosclerotic Cardiovascular disease				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH Int				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulmonary emboli									
19A. DATE OF OPERATION 2 NO		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 12-23 1966 to 1-20 1966 , that (I) (we) last saw the deceased alive on 1-20 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE B. H. Gross					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-20-66		
23C. PHYSICIAN'S NAME (Type) BRIAN H. GROSS					23D. ADDRESS UNION MEMORIAL HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-24-1966		24C. NAME OF CEMETERY or CREMATORY Odd Fellows Cemetery		24D. LOCATION (City, town, or county) (State) Shamokin Penna.			
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR LASSAHLN - 7401 Kelpair Rd		ADDRESS			

U. S. DEPT. OF AGRICULTURE

WASHINGTON, D. C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 00727	
BIRTH NO. 66 00727		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Melvin Kanely</u>		2. DATE AND HOUR OF DEATH <u>January 21 1966 5:05 P</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived/If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>20-03</u>			
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <u>South Baltimore General Hospital</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>2018 Ramsey Street</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Divorced</u>	8. DATE OF BIRTH <u>10-28-24</u>	9. AGE (In years last birthday) <u>41</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wireman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Westinghouse</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Raymond M. Kanely</u>				14. MOTHER'S MAIDEN NAME <u>PEARL L. BLANKLEIN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-12-7018</u>		17. INFORMANT ADDRESS <u>Pearl L. Kanely 2018 Ramsey St.</u>			
18. <u>260X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD. & CHF</u> <u>Diabetes Mellitus</u> <u>Diabetic Nephropathy & Uremia</u>				CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (a) (this hospital) attended the deceased from <u>December 12 1965</u> to <u>January 21 1966</u> , that (b) (we) last saw the deceased alive on <u>January 21 1966</u> and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>A. A. Frey</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1/21/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>A. A. Frey</u>				23D. ADDRESS M.D. <u>1213 Light St</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-24-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>London Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 24 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Geo. L. Schwab Funeral Home</u> <u>Franklin D. Miller 2101 Frederick Ave.</u>			

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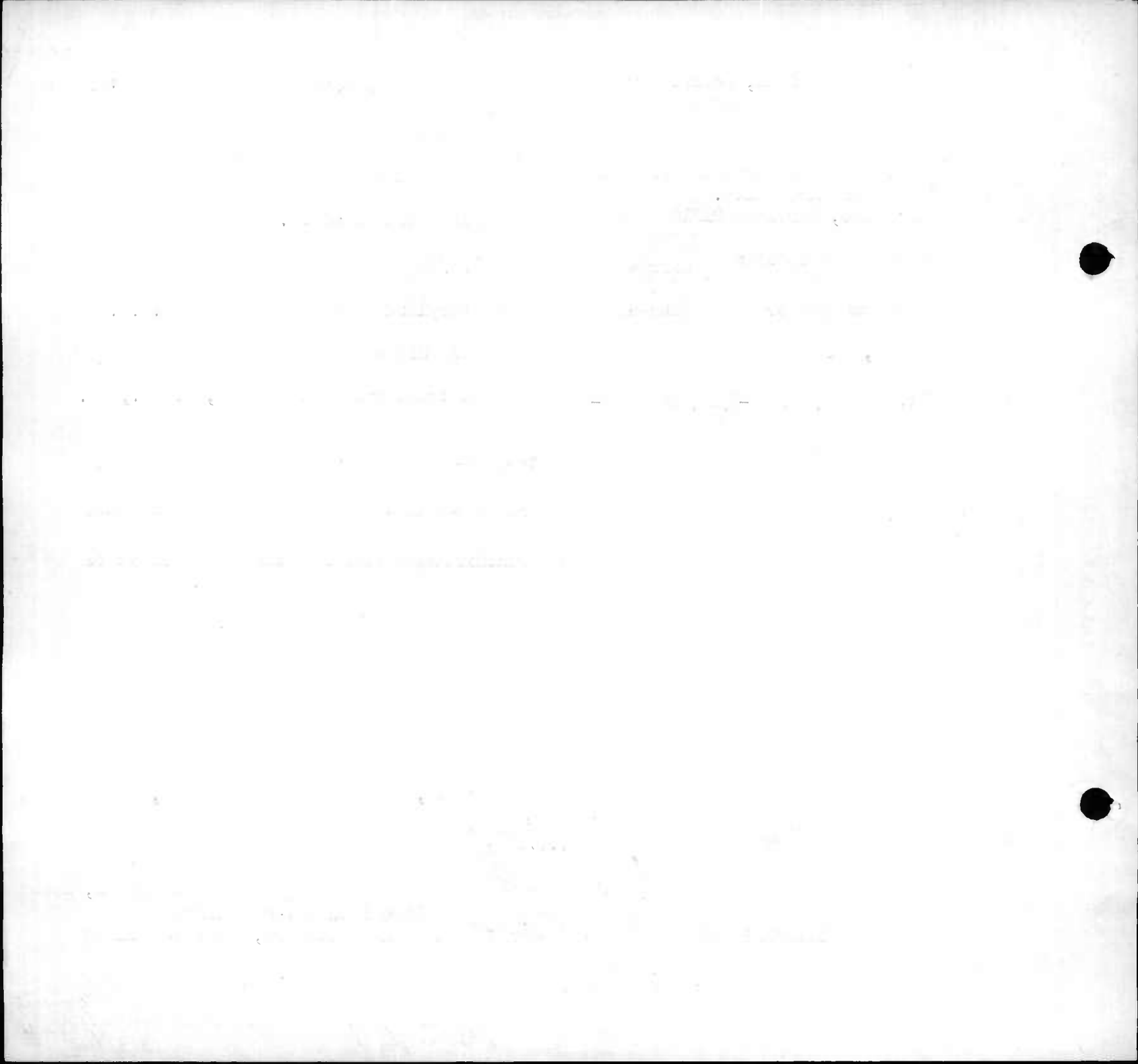
1905

1906

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00728		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 00728	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Mills, Robert Edward		2. DATE AND HOUR OF DEATH 1/21/66 5:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 21-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1206 Cleveland St.			
5. SEX Male	6. RACE Caucasian	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3/3/98	9. AGE (In years last birthday) 67	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storeroom Keeper		10B. KIND OF BUSINESS OR INDUSTRY Moral Academy		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Harry, Mills			14. MOTHER'S MAIDEN NAME Ella Mills		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 11/30/17-1/14/20		16. SOCIAL SECURITY NO. 218-10 3724		17. INFORMANT ADDRESS Veterans Hospital Records, Balto., Md.	
18. 326X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Cerebrovascular Accident		CAUSE OF DEATH (A) DUE TO Broncho-pneumonia (B) DUE TO Bronchiectasis and Emphysema (C)		INTERVAL BETWEEN ONSET AND DEATH 7 days 2 weeks 10 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from January 18, 1966 to January 21, 1966 , that (H) (we) last saw the deceased alive on January 21, 1966 and that in (H) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (H) view the body after death.					
23A. SIGNATURE William B. Joy				23B. DATE SIGNED January 21, 1966	
23C. PHYSICIAN'S NAME (Type) WILLIAM B JOY		23D. ADDRESS 3900 Loch Raven Boulevard Veterans Hospital Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/24/66		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem.	
24D. LOCATION (City, town, or county) (State) 5501 Frederick Ave		25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR John J. Cowan	
25C. FUNERAL DIRECTOR John J. Cowan		25D. ADDRESS 901 St. Johns Ave			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 00729

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

FRANCIS WEITZEL

2. DATE AND HOUR PRONOUNCED DEAD

January 20, 1966 2:10 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2012 Oakington Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

May 14, 1903

9. AGE (In years
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Auto Mechanic

10B. KIND OF BUSINESS OR INDUSTRY

Anchor Motor Freight Md

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Samuel S. Weitzel

14. MOTHER'S MAIDEN NAME

Frances Chalk

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

?

?

16. SOCIAL
SECURITY NO.

?

17. INFORMANT

ADDRESS

Rose C. Weitzel. 2012 Oakington St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Craniocerebral Injury.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Greenmount Ave. & 25th Street

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

1

20

'66

A

m.

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Driver in auto-auto collision.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/20/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1/24/66

23C. NAME of CEMETERY or CREMATORY

Woodlawn

23D. LOCATION

(City, town, or county)

(State)

Woodlawn, Md

24A. DATE REC'D BY HEALTH DEPT.

JAN 24 1966

24B. NAME OF REGISTRAR

Robert E. Jarboe

24C. FUNERAL DIRECTOR

Austin E. Bonovan-3818 Roland Ave

ADDRESS

VALLEY FORGE

MAY 11, 1903

RECEIVED

ANDERSON HOTEL, PHILADELPHIA

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ANDERSON HOTEL, PHILADELPHIA

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

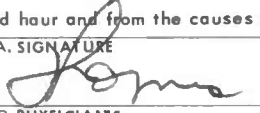
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 00730		CERTIFICATE OF DEATH		Registered No. 68 00730	
1. NAME OF DECEASED (Type or Print) Susan Marion COULLING				2. DATE AND HOUR OF DEATH January 19, 1966					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) House of Pines Nursing Home Baltimore, Md.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 13-07 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore City D. STREET ADDRESS (If rural, give location) 3801 Roland Ave.					
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Mar. 15, 1871	9. AGE (In years last birthday) 94 years	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Virginia (Matthews Co.)		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME William H. Oliver				14. MOTHER'S MAIDEN NAME Sarah E. Minter					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Marion O. P. Coulling ADDRESS Freeport, Long Island 63 Southside Ave.				
18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Acute Cardiac Arrest DUE TO (B) Arteriosclerotic Heart Disease DUE TO (C)					
				INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 11/31/1962 to 11/18/1966 , that (I) (was) last saw the deceased alive on 11/10/1966 and that (in my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.									
23A. SIGNATURE Albert B. Bradley				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 19 JAN 66	
23C. PHYSICIAN'S NAME (Type) Dr. Albert B. Bradley				23D. ADDRESS M.D. 4900 Belair Road Baltimore, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-22-66		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR C. Vernon Lemmon ADDRESS 4611 Park Heights Ave.					

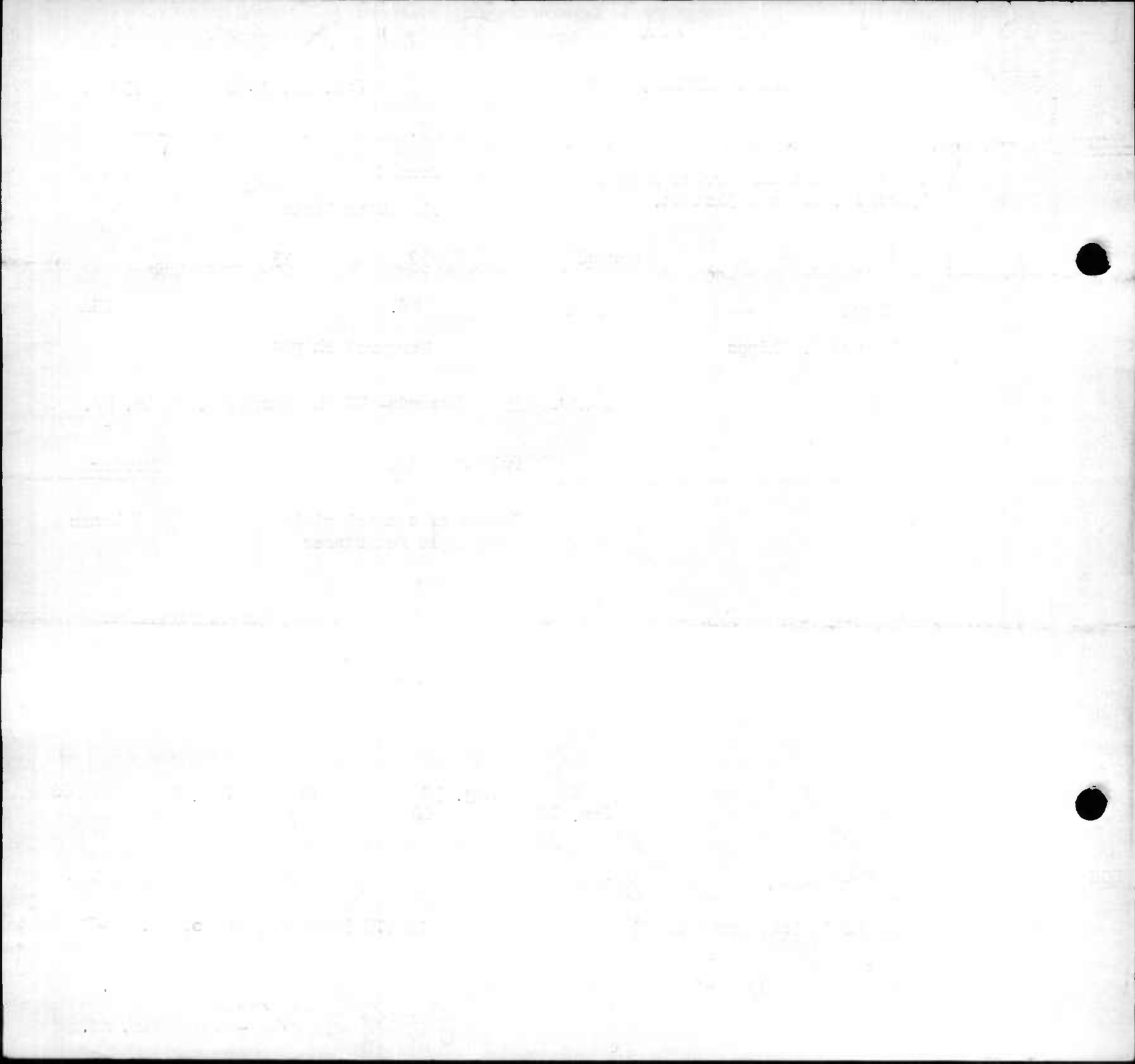
Best Case Court
Remains with Court

Walter D. Buehler

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

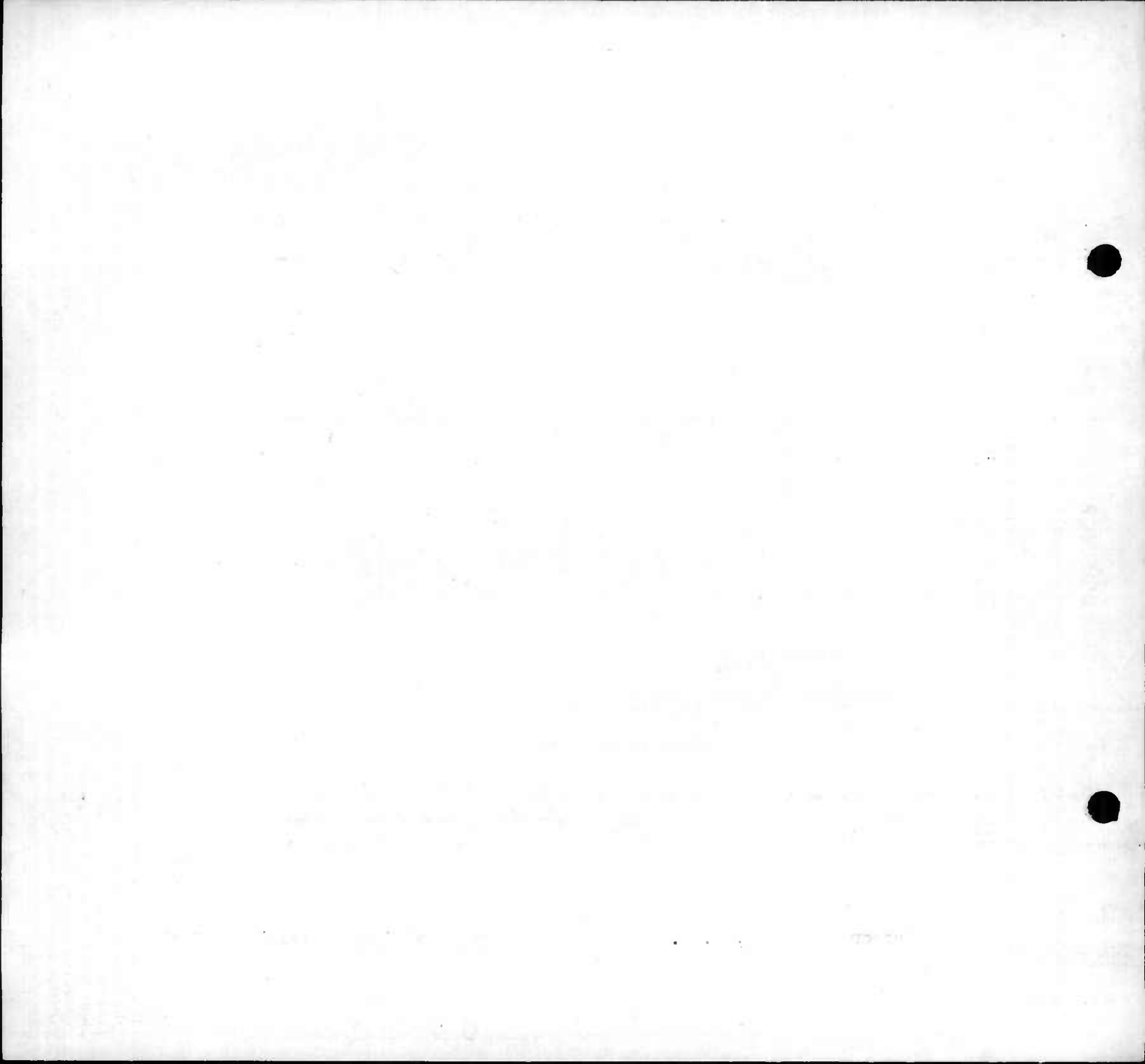
BIRTH NO. 66 00731		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 00731	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) DORIS LEE VIRGINIA DRYDEN			2. DATE AND HOUR OF DEATH Jan. 19, 1966 7:30 P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Pk. Drive & 31st St.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Arnold D. STREET ADDRESS (If rural, give location) 331 Buena Vista		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1/22/32	9. AGE (In years last birthday) 33	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY State Gov't	11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Edward W. Phipps			14. MOTHER'S MAIDEN NAME Margaret Phipps		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-16-4901	17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.		
18. 15 / X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Pulmonary edema DUE TO (B) Cancer of stomach with multiple metastases DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH Terminal 7 Years
			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (✓) (this hospital) attended the deceased from Aug. 30 19 65 to Jan. 19 19 66 , that (✓) (we) last saw the deceased alive on Jan. 19 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (✓) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 1/20/66	
23C. PHYSICIAN'S NAME (Type) Thomas J. Lau, Surgeon (R)			23D. ADDRESS M.D. US PHS Hospital, Balto, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 1/24/66	24C. NAME OF CEMETERY or CREMATORY Hillcrest Memorial		24D. LOCATION (City, town, or county) (State) Annapolis Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR'S ADDRESS Beverly E. Hopping Hopping Funeral Home - Annapolis, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

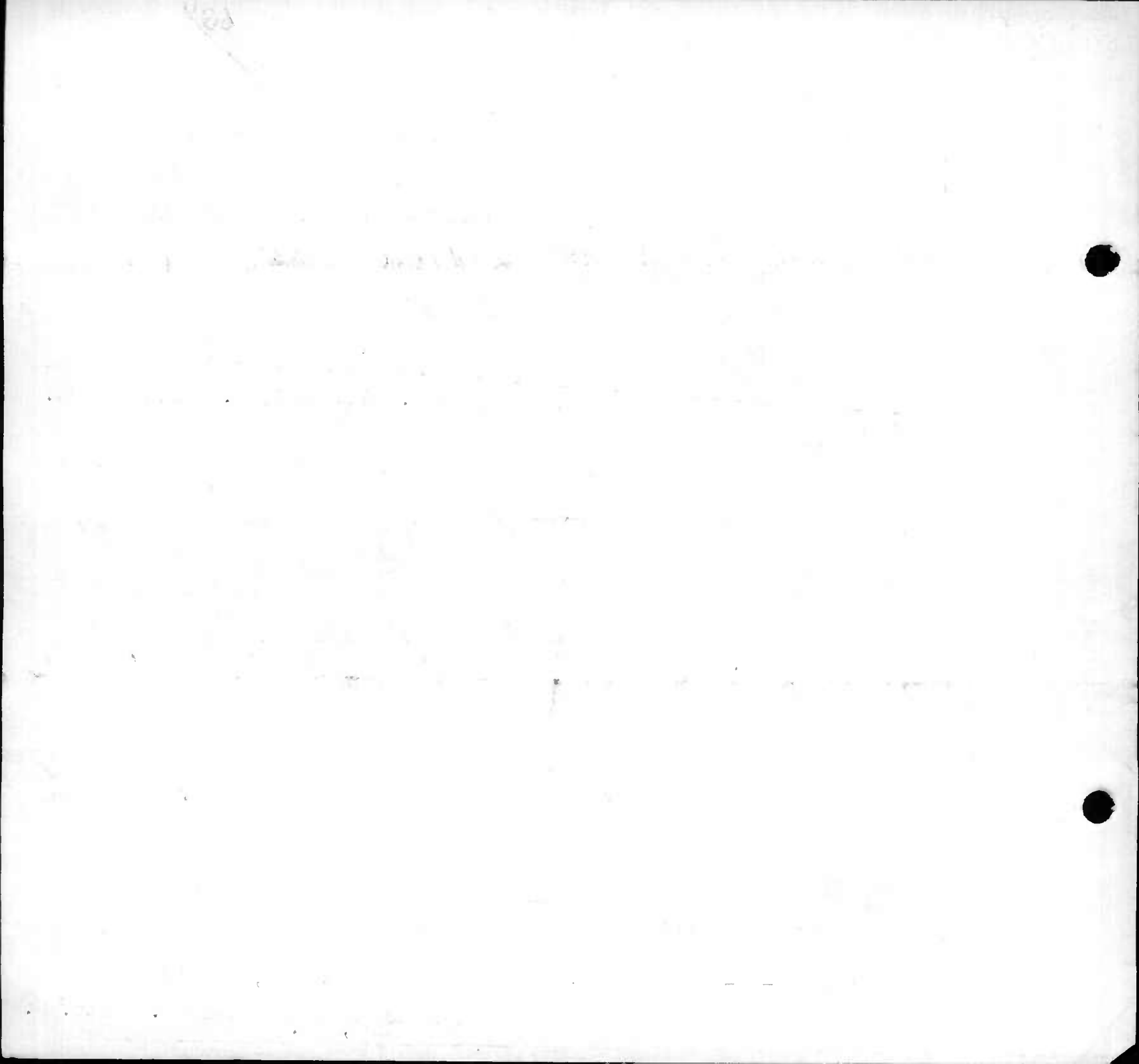
BALTIMORE CITY HEALTH DEPARTMENT										
66 00732 CERTIFICATE OF DEATH					Registered No. 66 00732					
BIRTH NO. 66 00732					M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <i>Mollie Ferrell</i>					2. DATE AND HOUR OF DEATH <i>1-21-66 2:10 A.M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>South Baltimore General Hosp.</i>					A. STATE <i>Maryland</i>					
					B. COUNTY <i>25-04</i>					
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>					D. STREET ADDRESS (If rural, give location) <i>#21225</i>					
					408 Pontiac Ave.					
5. SEX <i>F</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>7-9-1897</i>	9. AGE (In years last birthday) <i>74</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>NONE</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>white</i>			14. MOTHER'S MAIDEN NAME <i>Jennie Joyner</i>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Family</i>		ADDRESS <i>Same</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH					
					INTERVAL BETWEEN ONSET AND DEATH					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					(A) <i>Diabetes mellitus</i>					
					DUE TO					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					(B) <i>MIASE VD</i>					
					DUE TO					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					(C) <i>Probably cerebral hemorrhage</i>					
					DUE TO					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					2° to 4°					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No.</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that the (this hospital) attended the deceased from <i>1-19</i> 19 <i>66</i> to <i>1-21</i> 19 <i>66</i> , that the (we) last saw the deceased alive on <i>1-21</i> 19 <i>66</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <i>Vernon Albertson, M.D.</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <i>1-21-66</i>		
23C. PHYSICIAN'S NAME (Type) <i>Vernon Albertson, M.D.</i>					23D. ADDRESS <i>South Baltimore General Hospital</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-24-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Green Haven Cem.</i>			24D. LOCATION (City, town, or county) (State) <i>Green Bay Md</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 24 1966</i>			25B. NAME OF REGISTRAR <i>R. L. F. 23</i>			25C. FUNERAL DIRECTOR <i>McGully & H</i>			ADDRESS <i>237 Potomac Ave</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00733				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00733	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) FREDERICK ALBERT COLE				2. DATE AND HOUR OF DEATH 1-19-66 1 3 15 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BON SECOURS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 20-03 1913-15 W. BALTIMORE ST. 21223			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1/4/1901	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FUNERAL DIRECTOR			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? UNITED STATES
13. FATHER'S NAME JOHN S. COLE				14. MOTHER'S MAIDEN NAME ANNA S. SMITH			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Anne R. Cole 1913 W. Baltimore St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Bronchopneumonia				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH one month	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Malig. Metastasis in liver & lung				(B) DUE TO		one year	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bone Tumor, Hernia				(C) DUE TO			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1-3-66 to 1-19-66 , that (I) (we) last saw the deceased alive on 1-19-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Samuel C. Chao				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-19-66	
23C. PHYSICIAN'S NAME (Type) SAMUEL C. CHAO				23D. ADDRESS Box Secours Hospital, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE 1-22-66		24C. NAME OF CEMETERY OR CREMATORY Lorraine Mausoleum		24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR Robert A. Fairbank		25C. FUNERAL DIRECTOR Cole Funeral Home		ADDRESS 1913 W. Balto. St. Baltimore, Md. 21223	



The body of William Heck was released on approval by Dr. Petty to The Johns Hopkins Hospital 1-20-66
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH											
William Heck				1-20-66 6:15a M.											
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)											
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY											
The Johns Hopkins Hospital				Maryland											
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)											
				Baltimore											
				D. STREET ADDRESS (If rural, give location)											
				2214 East Fairmount Avenue											
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. If Under 1 Yr. Months Days		11. If Under 24 Hrs. Hours Min.			
Male		White		Widow		Oct. 5, 1870		95							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
ret- Painter				Self-employed				Baltimore, Md.							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME											
unknown				unknown											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
				219-18-2418				Adolph E. Heck, son, above							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH							
Pneumonia				Pneumonia				6 DAYS							
ANTECEDENT CAUSES				Aspiration				6 DAYS							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Ex @ hup				8 DAYS							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Angerine heart failure (ASCD)											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
2								YES				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
				HOME				2214 E. FAIRMONT AVE 6-03							
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?							
1 12 66 2 AM				While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>				FELL OVER CHAIR							
22. I certify that (I) (this hospital) attended the deceased from 1/14 19 66 to 1/20 19 66.				that (I) (we) last saw the deceased alive on 1/20 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (Did) (did not) view the body after death.											
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED							
J. R. SPENCER								1/20/66							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS											
J. R. SPENCER				M.D. JOHNS HOPKINS HOSP BALTIMORE MD											
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE				24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
Burial				1/24/66				Sacred Heart Cemetery				Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR				ADDRESS			
JAN 24 1966				Robert S. Taylor				Schimunek Funeral Home, Inc.				22601 E. Madison St.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 66 00735	
BIRTH NO. 66 00735		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MR. JAMES J. FUKA		2. DATE AND HOUR OF DEATH 1/20/66 8:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 7 MERCY HOSPITAL INC.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE 5 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 5 D. STREET ADDRESS (If rural, give location) 805 N. COLLINGTON			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 11-15-01	9. AGE (In years last birthday) 64	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beth. Steel RETIRED Maintenance		
11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME JOHN FUKA			14. MOTHER'S MAIDEN NAME ROSE KOUTNIK			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. 213-09-1057			17. INFORMANT Mary (nee Pospisil) Fuka, wife, above				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) MYOCARDIAL INFARCTION (B) DUE TO (C) CARCINOMA OF RECTUM INTERVAL BETWEEN ONSET AND DEATH ? 1 DAY ? DURATION				19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 1/20/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED INTESTINAL OBSTRUCTION		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 12:40 PM 1/20/66 to 8:15 PM 1/20/66, that (I) (we) last saw the deceased alive on 8:15 PM 1/20/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Eusebio P. Gonzalez				23B. DATE SIGNED 1/21/66		23C. PHYSICIAN'S NAME (Type) EUSEBIO P. GONZALES	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/25/66		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR R. A. 2, Farber		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 2601 E. Madison St.		25D. ADDRESS	

66 00736

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66-00736

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

TIMOTHY TROGAN

2. DATE AND HOUR PRONOUNCED DEAD

January 19, 1966 9:40 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4300 Willshire Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married

8. DATE OF BIRTH

Feb. 26, 1911

9. AGE (In years
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Lt. Police

10B. KIND OF BUSINESS OR INDUSTRY

City Jail

11. BIRTHPLACE (State or foreign country)

Soubon, Czech.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

Emma Urban

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

212-07-8698

17. INFORMANT

ADDRESS

Donald Trojan, son, above

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A).....
DUE TOArteriosclerotic cardiovascular
disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B).....
DUE TO

(C).....

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-20-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1/22/66

23C. NAME OF CEMETERY or CREMATORY

Baltimore Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

JAN 24 1966

24B. NAME OF REGISTRAR

Robert E. Farber

24C. FUNERAL DIRECTOR

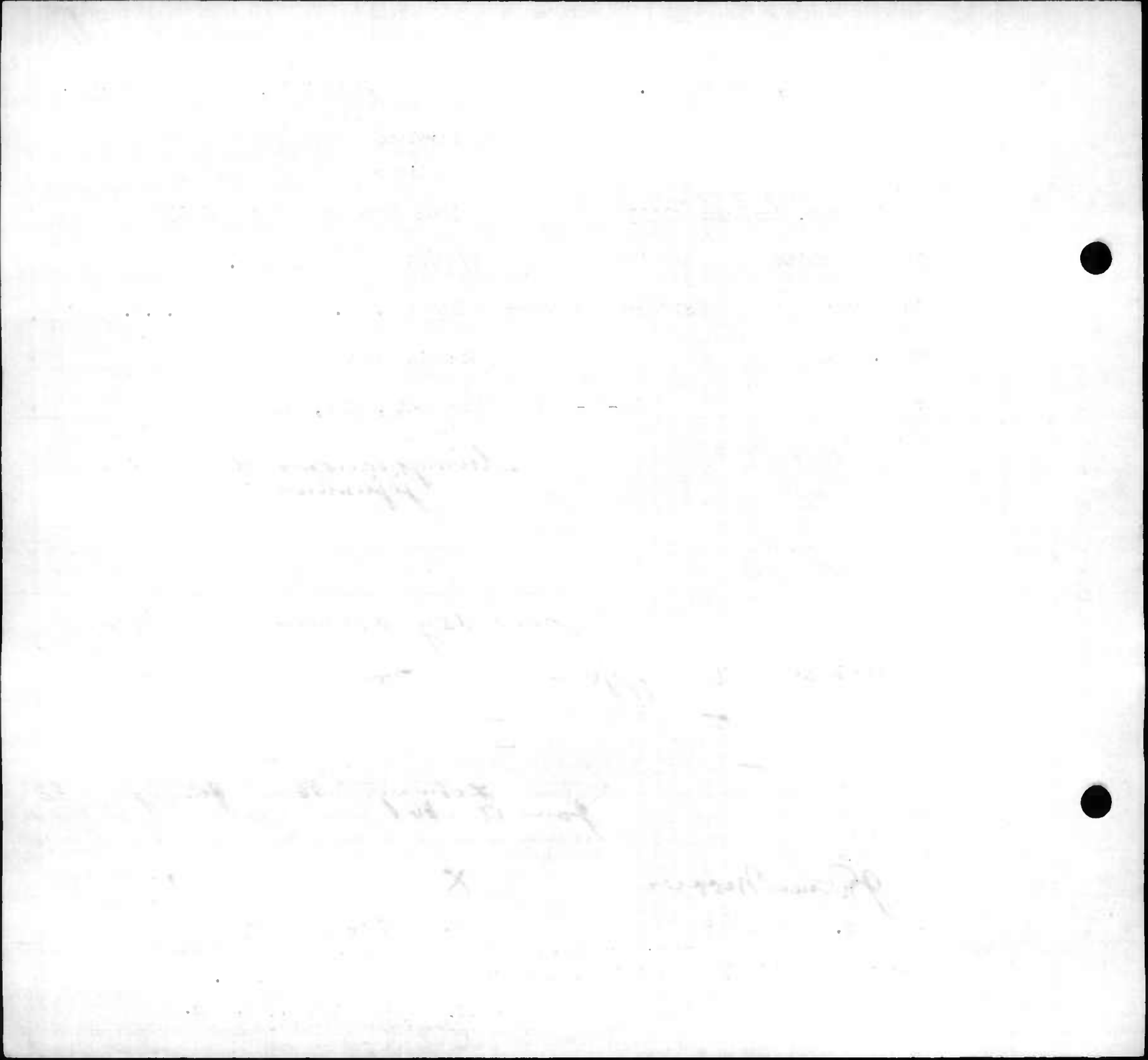
Schimmeler Funeral Home, Inc.
3331 Brehms Lane

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Baltimore City Health Department	
CERTIFICATE OF DEATH				Registered No. 66 00737	
BIRTH NO. 66 00737		M.E. CASE NO. 66 00737			
1. NAME OF DECEASED (Type or Print) RUTH, CHARLES G.			2. DATE AND HOUR OF DEATH JANUARY 19, 1966 10:30 p. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3462 Cardenas Avenue Baltimore, Maryland 21213			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3462 Cardenas Avenue 21213		
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 5/20/85	9. AGE (In years last birthday) 80 yrs.	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Layer		10B. KIND OF BUSINESS OR INDUSTRY McCullough Brothers		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME John G. Ruth			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 216-09-8987		17. INFORMANT Mary Ruth, wife, above
18. 152.7 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <i>Leimyosarcoma of jejunum</i> (B) (C) INTERVAL BETWEEN ONSET AND DEATH 1 yr.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>secondary anemia</i>			INTERVAL BETWEEN ONSET AND DEATH 1/2 yr.		
19A. DATE OF OPERATION 11-2-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>tumor of jejunum</i>		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from February 1956 to January 1966, that (I) (we) last saw the deceased alive on Jan. 17 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Dr. Duer Moores</i>				23B. DATE SIGNED 1-20-66	
23C. PHYSICIAN'S NAME (Type) Dr. Duer Moores			23D. ADDRESS 3105 Belair Road #13		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/22/66		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery	
24D. LOCATION Baltimore, Md.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR <i>John E. Schimunek</i>		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane #13	
ADDRESS					



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EZRA DUDDING

2. DATE AND HOUR PRONOUNCED DEAD
January 19, 196611:38 A.
M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

501 S. Curley Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

9-13-1891

9. AGE (In years
last birthday)

74

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Cab Driver

10B. KIND OF BUSINESS OR INDUSTRY

Transportation

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Edward

14. MOTHER'S MAIDEN NAME

Sarah

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

—

17. INFORMANT

Mrs. Rebecca Dudding
501 S. Curley St., Baltimore 24, Md.

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular
DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-20-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1-22-66

23C. NAME OF CEMETERY or CREMATORY

Glen Haven Cemetery

23D. LOCATION

(City, town, or county)

(State)

Glen Burnie, Md.

24A. DATE REC'D BY HEALTH DEPT.

JAN 24 1966

24B. NAME OF REGISTRAR

John E. Farber

24C. FUNERAL DIRECTOR

Nicholas T. Matthews

ADDRESS

3021 Eastern Ave., Baltimore, Md.

WALLACE H. BIRGE

4-12-1911

Virginia

Swan

Mr. Robert D. Boring
211 S. 1st St. Richmond, Va.

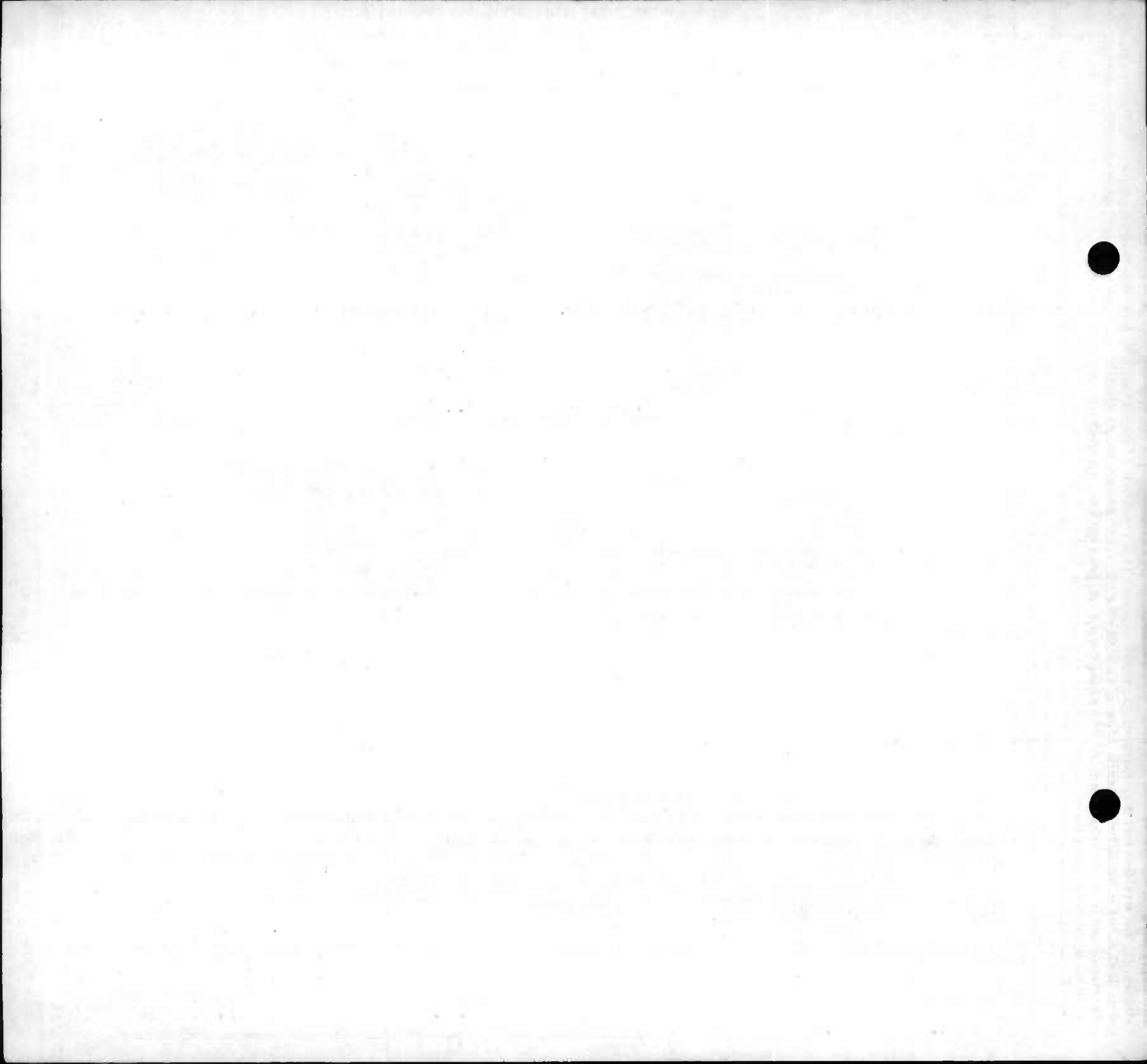
Misses Clara Anna Conner, Glen Burnie, Md.

Nicholas T. Hoffman
211 S. 1st St. Richmond, Va.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00739		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00739	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Miss Lillian B. Bialek (Bronislawa)		2. DATE AND HOUR OF DEATH 1-22-66 2:50 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital		A. STATE Maryland B. COUNTY 27-01			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 4702 Crosswood Avenue			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 9-11-1899	9. AGE (In years last birthday) 66	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Examiner		10B. KIND OF BUSINESS OR INDUSTRY Uniform Mfg.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOSEPH Bialek		14. MOTHER'S MAIDEN NAME KATHERINE Lebdowicz	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No -		16. SOCIAL SECURITY NO. 214-20-7435		17. INFORMANT Mrs. Josephine Luczkowski, 4702 Crosswood Av	
18. 175.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) Generalized Carcinomatosis due to ovarian cancer (B) (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-18-66 to 1-22-66, that (I) (we) last saw the deceased alive on Jan. 22 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Josephine Brunidor		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-22-66	
23C. PHYSICIAN'S NAME (Type) Josephine Brunidor		23D. ADDRESS Bon Secours Hospital, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/25/66		24C. NAME OF CEMETERY or CREMATORY Holy Rosary	
24D. LOCATION Baltimore, Maryland		24E. LOCATION (If outside city limits, give county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR R. E. Fairbank		25C. FUNERAL DIRECTOR M.F. SADOWSKI & SONS, 1808 EASTERN AVE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00740	
BIRTH NO. 66 00740				M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) ETHEL ALMA MILLER			2. DATE AND HOUR OF DEATH 1-21-66 5:40 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MONTEBELLO STATE HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 19 COCKPIT ST.		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 11-10-01	9. AGE (In years last birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME JEFFERSON MILLER		
14. MOTHER'S MAIDEN NAME Louise FINK			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 219-362182			17. INFORMANT ADDRESS HOSPITAL RECORDS		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CARCINOMA OF CERVIX ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. 8 MOS.					INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I)(this hospital) attended the deceased from 9-27 1965 to 1-21 1966 , that (I)(we) last saw the deceased alive on 1-21 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I)(We) (did) (did not) view the body after death.					
23A. SIGNATURE Irving L. Cooperstein				23B. DATE SIGNED 1-21-66	
23C. PHYSICIAN'S NAME (Type) Irving L. Cooperstein				23D. ADDRESS MONTEBELLO STATE HOSP. BALTO. MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/24/1966		24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR ADDRESS Eugenia K. Seitz 5209 York Road Baltimore, Md. 21212			



66 00741

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 00741

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Carl H. Smith

2. DATE AND HOUR PRONOUNCED DEAD

1/18/66 2:10 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

125 S. Cheapside St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

Aug 21, 1913

9. AGE (In years
last birthday)

52

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Presseer

10B. KIND OF BUSINESS OR INDUSTRY

Dry cleaning

11. BIRTHPLACE (State or foreign country)

Harrisburg, Pa.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Herbert L. Smith

14. MOTHER'S MAIDEN NAME

Bertha Stahl

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

215-55-3755

17. INFORMANT

Raymond Smith

4501 Berkley St.
Harrisburg, Pa.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Lobar pneumonia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

partial

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/18/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Jan 20-66

23C. NAME of CEMETERY or CREMATORY

Holy Cross

23D. LOCATION

(City, town, or county)

(State)

Harrisburg-Dauphin-Pa

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

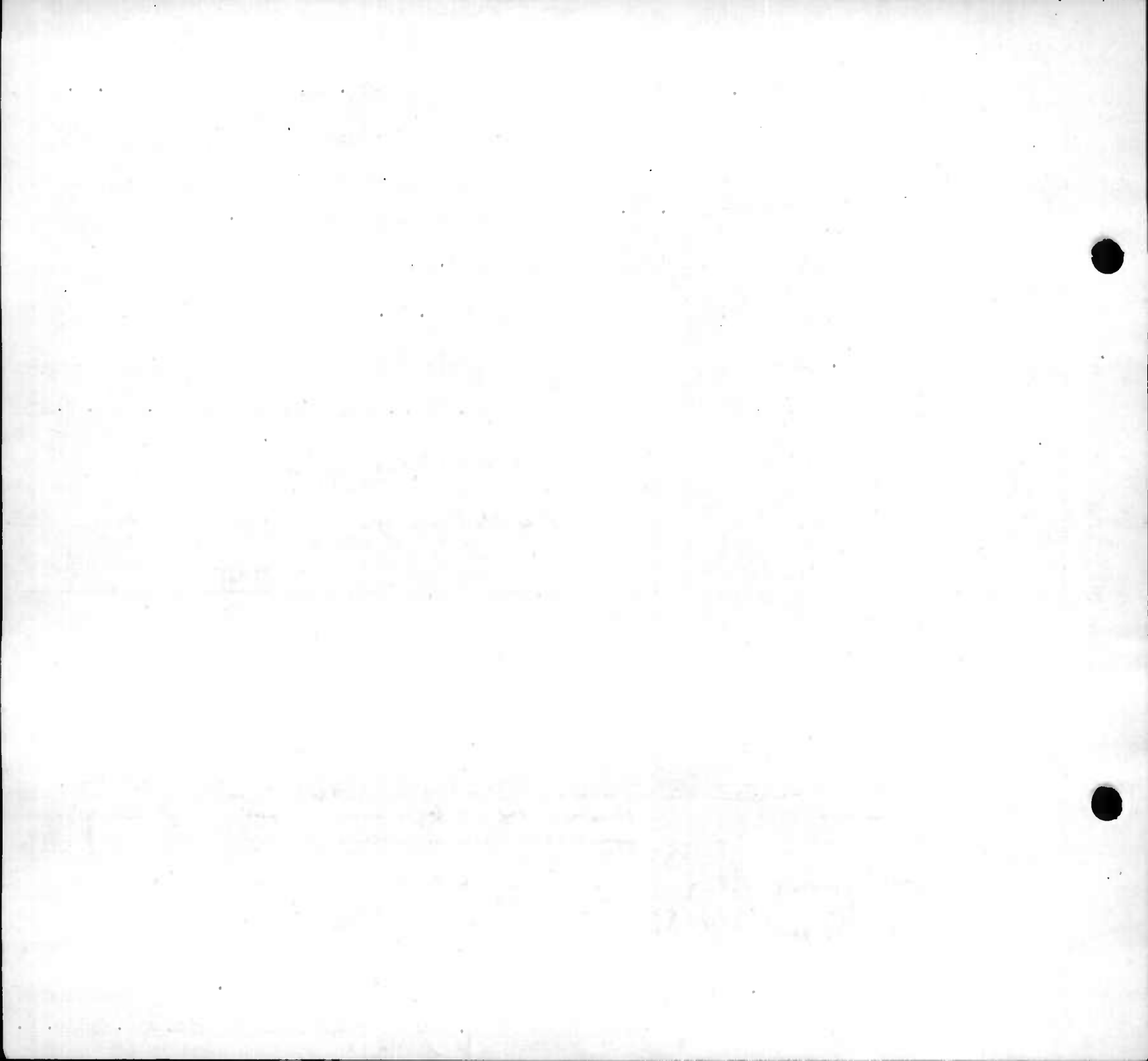
ADDRESS

JAN 24 1966

R. E. 2, F. A. M.

J. F. Eline & Son-Reisterstown, Md.

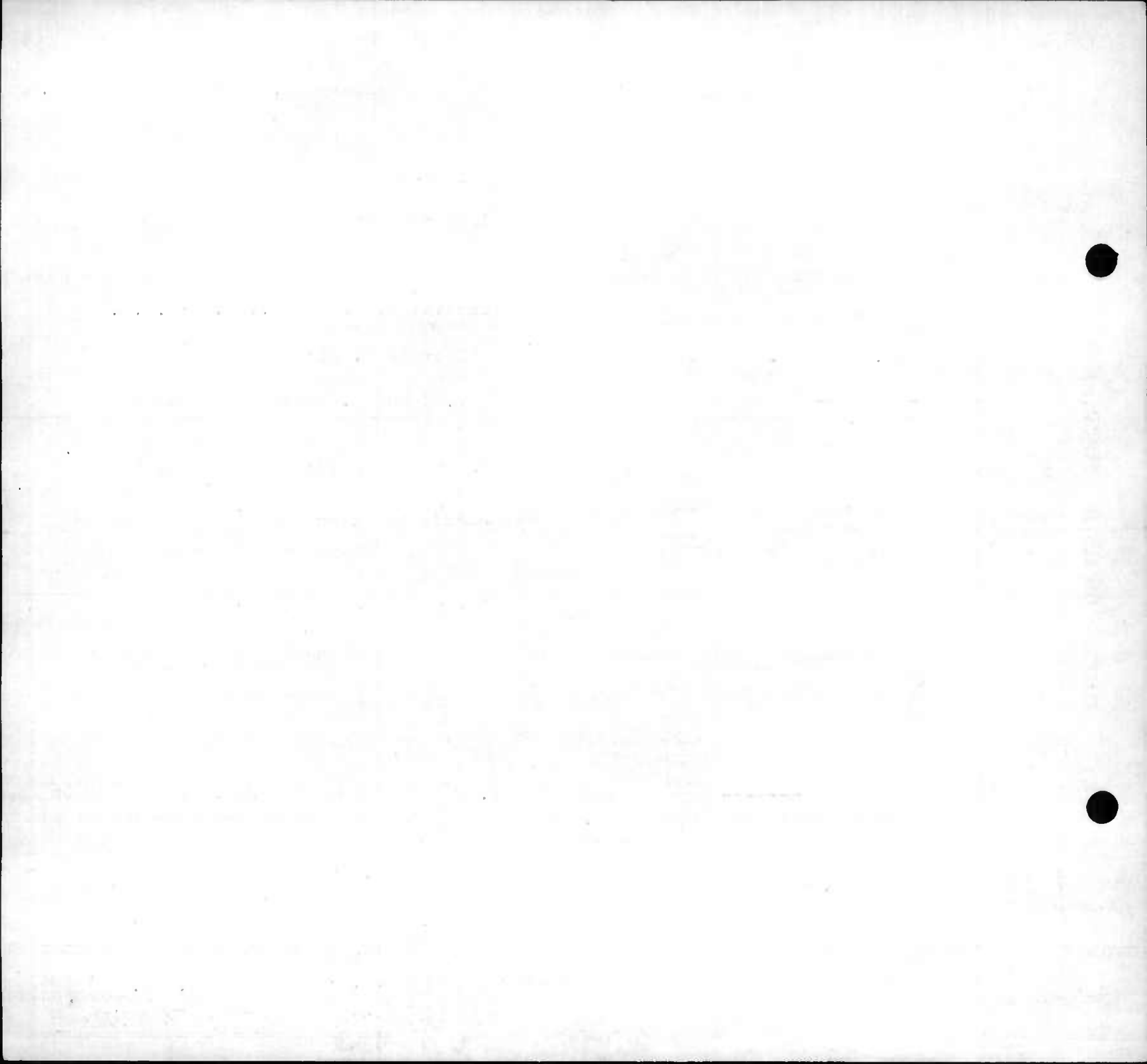
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

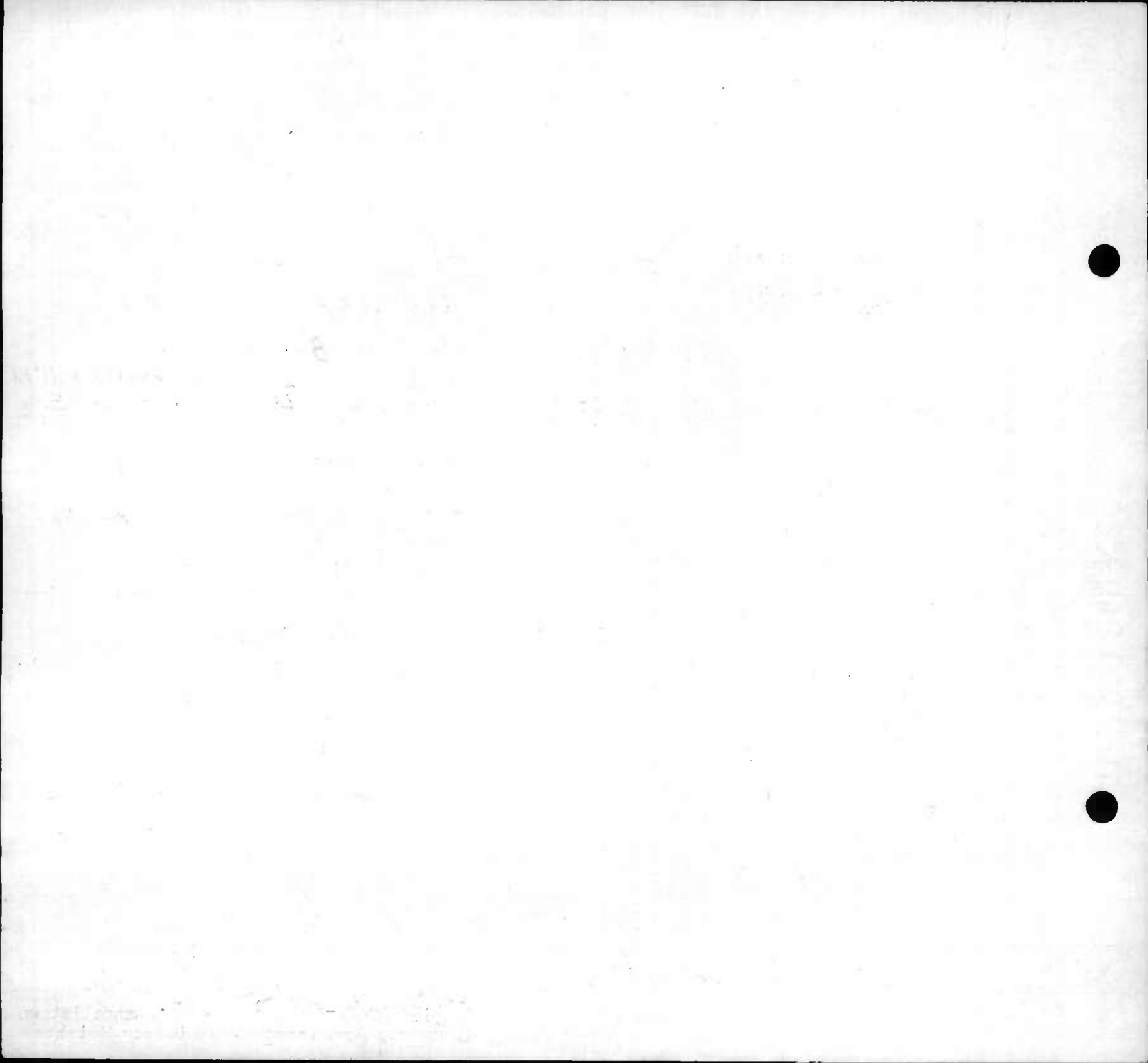
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 00743		REGISTERED NO. 66 00743	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) RUTH NICHOLS JONES				2. DATE AND HOUR OF DEATH January 19, 1966 1 a.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1301 Argonne Drive				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 9-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1301 Argonne Drive			
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH April 25, 1894		9. AGE (In years last birthday) 71	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Johnsville, Fred. Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Dr. Frank H. Sidwell				14. MOTHER'S MAIDEN NAME Georgie R. Nichols			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -- --		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. James H. Jones		ADDRESS same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 155.1 I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Carcinoma Common duct DUE TO (B) Metastasis to liver DUE TO (C) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. INTERVAL BETWEEN ONSET AND DEATH 1 year 3 months							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Dec. 20 19 65 to Jan. 19 19 66 , that (I) (we) last saw the deceased alive on Jan. 18 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Carl F. Benson, M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Jan. 19, 1966	
23C. PHYSICIAN'S NAME (Type) Carl F. Benson				23D. ADDRESS 5111 York Rd Balto 12 Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 1/22/66		24C. NAME OF CEMETERY or CREMATORY Central Cemetery		24D. LOCATION (City, town, or county) (State) Frederick County, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR J. S. Myers, Jr. Westminster, Md.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00744		CERTIFICATE OF DEATH		Registered No. 66 00744	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ROBERT R. QUESENBERRY		2. DATE AND HOUR OF DEATH 1/20/66 9:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 6825 WINDSON MILL RD			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH 2/10/05	9. AGE (In years last birthday) 60	10. CITIZEN OF WHAT COUNTRY? USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, or last held) Night Guard		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) KENTUCKY	
13. FATHER'S NAME ROBERT QUESENBERRY		14. MOTHER'S MAIDEN NAME MARTHA BINGHAM			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes - WWI - ARMY		16. SOCIAL SECURITY NO. 227-09-675X	17. INFORMANT SISTER ZELLA STRONG SAME		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) METASTATIC CARCINOMA TO PLEURA		CAUSE OF DEATH (A) METASTATIC CARCINOMA TO PLEURA (B) ADENOCARCINOMA OF STOMACH (C)		INTERVAL BETWEEN ONSET AND DEATH ? 1 YEAR 2 YEARS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CHRONIC BRONCHITIS AND EMPHYSEMA					
19A. DATE OF OPERATION 4/25/64		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA STOMACH		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/26/65 to 1/20/66, that (I) (we) last saw the deceased alive on 1/20/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Donald Feldner		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/20/66	
23C. PHYSICIAN'S NAME (Type) Donald Feldner		23D. ADDRESS Maryland General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-25-66		24C. NAME OF CEMETERY or CREMATORY Mt Olive Cemetery	
24D. LOCATION Randallstown Md		24E. FUNERAL DIRECTOR Gordon W. ...		24F. ADDRESS Hillsworth Armacost 4600 Liberty Heights	
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR Robert E. ...		25C. ADDRESS Hillsworth Armacost 4600 Liberty Heights	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00745	
BIRTH NO. 66 00745				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ALLEN I. MILLISON		2. DATE AND HOUR OF DEATH 1-14-66 6:00 a. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION Ventnor Lodge 526 S. Chapelgate Lane		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-38 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3511 Fairview Avenue			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married		8. DATE OF BIRTH 58 yrs.	9. AGE (In years last birthday) 58 yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) St. Marys County, Md.	
13. FATHER'S NAME Charles Millison		14. MOTHER'S MAIDEN NAME Jennie Rose Sachs			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-52-3048		17. INFORMANT ADDRESS Mr. Z. Harry Millison, 6301 Pk. Heights Ave.	
18. 330X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) Cerebral Hemorrhage DUE TO (B) Jacksonian Epilepsy Interval DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 18 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Work Not White At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 48 to January 14 19 66 , that (I) (we) last saw the deceased alive on January 12 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Helmut Prager</i>				23B. DATE SIGNED 1/14/66	
23C. PHYSICIAN'S NAME (Type) Dr. Helmut Prager				23D. ADDRESS M.D. 11 E. Chase Street	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/14/66		24C. NAME of CEMETERY or CREMATORY Beth Tfiloh	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR Sol Levinson & Bros. Inc.		25C. FUNERAL DIRECTOR ADDRESS 6010 Reisterstown			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00746				BALTIMORE CITY HEALTH DEPARTMENT		66 00746	
CERTIFICATE OF DEATH				Registered No.			
1. NAME OF DECEASED (Type or Print) <i>George L Koenig</i>				2. DATE AND HOUR OF DEATH <i>21 Jan 1966 9:25 A. M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>9-05</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>42 Sinai Hospital of Baltimore</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
D. STREET ADDRESS (If rural, give location) <i>906 Gorsuch Ave</i>							
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <i>23 June 1893</i>	9. AGE (In years last birthday) <i>72</i>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Rooper</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George L Koenig</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Willis</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes 1st W. W.</i>		16. SOCIAL SECURITY NO. <i>212-03-0469</i>		17. INFORMANT <i>Miss Ann Koenig</i>			
				ADDRESS <i>906 Gorsuch Ave</i>			
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Acute myocardial infarction</i> DUE TO (B) <i>Hypertension; Arteriosclerotic Cardiovascular Disease</i> DUE TO (C) <i>with Congestive Heart Failure</i>			
				INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Severe Pernicious Anemia</i>							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <i>(X)</i> (this hospital) attended the deceased from <i>18 Jan</i> 19 <i>66</i> to <i>21 Jan</i> 19 <i>66</i> , that (I) <i>(X)</i> last saw the deceased alive on <i>21 Jan</i> 19 <i>66</i> and that in (my) <i>(X)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(X)</i> (did) (did not) view the body after death.							
23A. SIGNATURE <i>Michael L. Levin</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>21 Jan 66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Michael L. Levin</i>				23D. ADDRESS <i>SINAI HOSPITAL of BALTIMORE</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/26/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>J. Melville Jenkins</i>		25C. FUNERAL DIRECTOR <i>2713 Kirk</i>			

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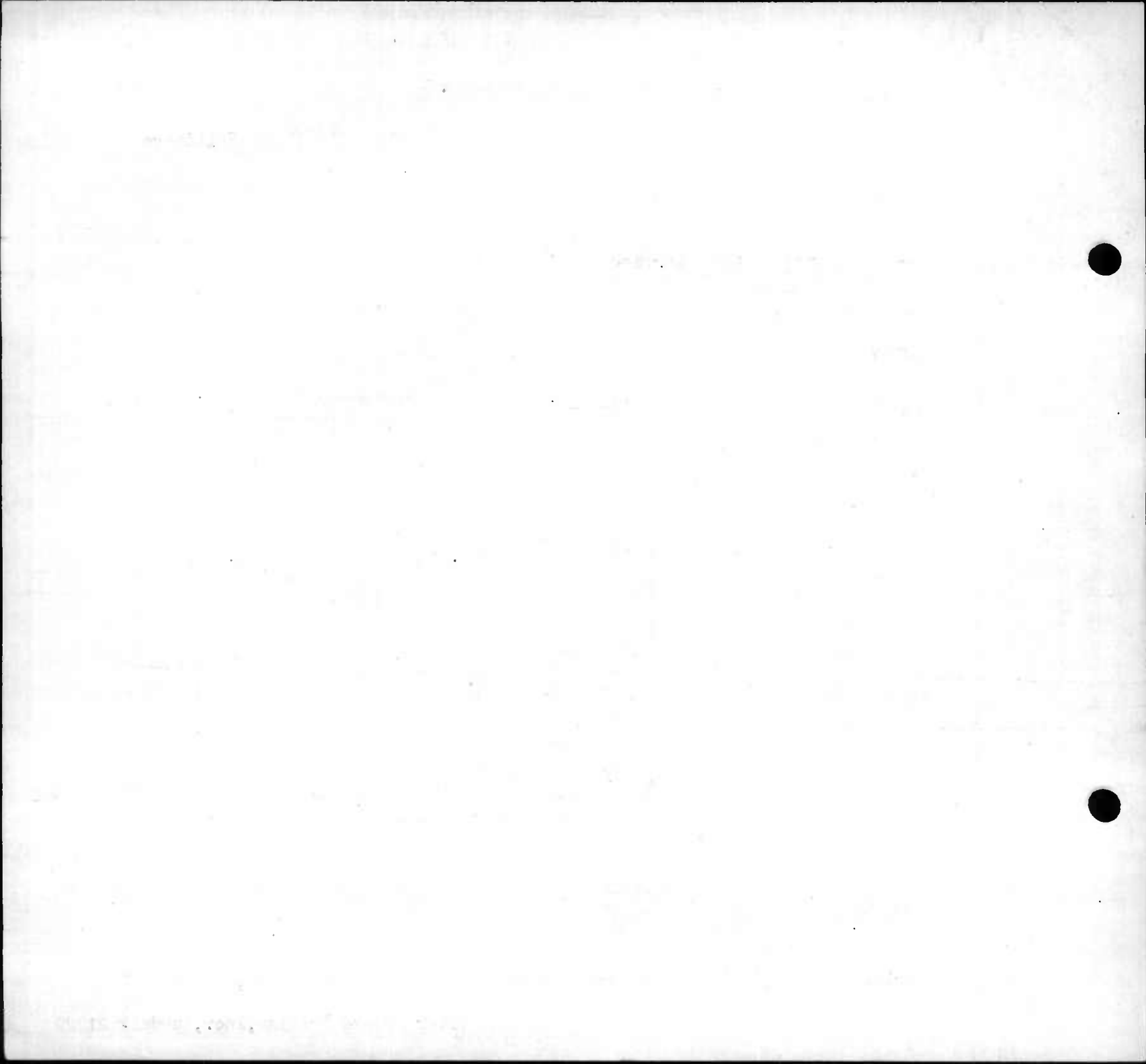
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>66-00747</u>	
BIRTH NO. <u>66-00747</u>							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <u>FLORENCE MAY HENDRICKS</u>		2. DATE AND HOUR OF DEATH <u>1-20-66</u> <u>6:20 P.M.</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>36 FRANKLIN SQUARE HOSPITAL</u>				A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u>			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>DUNDALK</u>			
				D. STREET ADDRESS (If rural, give location) <u>20 LEE WAY</u> <u>22</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>married</u>		8. DATE OF BIRTH <u>8-29-83</u>	9. AGE (In years last birthday) <u>82</u>	10. If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>9 Unknown) PIERCE</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH THORLEY</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-07-3359B</u>		17. INFORMANT ADDRESS <u>MEDICAL RECORDS</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>420.01</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>VENTRICULAR FIBRILLATION</u> DUE TO <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO <u>CONGESTIVE HEART FAILURE</u> DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1-20</u> 19 <u>66</u> to <u>1-20</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1-20</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Vacinto V. de Borja</u> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1-20-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>VACINTO V. DE BORJA</u> M.D.				23D. ADDRESS <u>F.S.H. 110 N. CALHOUN ST BALTIMORE MD.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/24/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Parkwood Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 24 1966</u>		25B. NAME OF REGISTRAR <u>Walter Brooks Bradley, Inc.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Dundalk 21222</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 00748	
BIRTH NO. 66 00748		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CECILIA MARIE HURKA		2. DATE AND HOUR OF DEATH 1-17-66 11:25 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give sheet address or location) LITTLE SISTERS OF THE POOR 901200 VALLEY STREET BALTIMORE, MARYLAND 21202				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1200 VALLEY ST.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH Nov. 16, 1885	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PACKING VEGETABLES		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ANDREW STUBELESKI				14. MOTHER'S MAIDEN NAME MARY N. BARANOWSKA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-09-4114A		17. INFORMANT ADDRESS LITTLE SISTERS OF THE POOR 1200 VALLEY ST. BALTIMORE, MD.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO Cerebral accident - stroke of left side C.S.C.V.D. (B) DUE TO (C) Generalized arteriosclerosis			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1964 to Jan 17 1966, that (I) (we) last saw the deceased alive on Jan 17 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Stanley Ankudas				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1-20-66	
23C. PHYSICIAN'S NAME (Type) Stanley Ankudas				23D. ADDRESS M.D. 1802 W Baltimore St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/21/66		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cen		24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR Robert E. Farkas		25C. FUNERAL DIRECTOR F. W. Ozyewski		ADDRESS 930 Eastern Ave.	

1-
#

27. 11. 1942

27. 11. 1942
27. 11. 1942

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

John W. Gill

2. DATE AND HOUR PRONOUNCED DEAD

1/22/66 2:30 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

38

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1821 W. Baltimore St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

DIVORCED

8. DATE OF BIRTH

4-6-1922

9. AGE (In years
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

GEN. CONTRACTOR

11. BIRTHPLACE (State or foreign country)

WISE - N.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ERNEST GILL

14. MOTHER'S MAIDEN NAME

ISABELLE COLEMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WWII

16. SOCIAL
SECURITY NO.

244-12-1578

17. INFORMANT

ADDRESS

WM. H. GILL 931 S. Bayliss St

18.

E 981X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot wound of chest, involving heart
DUE TO and right lung

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

2435 Maisel St.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
1 22 66 1:30 p.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

shot in chest

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/23/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1/23/66

23C. NAME OF CEMETERY or CREMATORY

BALTO NATIONAL

23D. LOCATION

(City, town, or county)

BALTO MD

(State)

24A. DATE REC'D BY HEALTH DEPT.

JAN 24 1966

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Marshall P. Hays (382) Gilmor St.

WALTER H. H. H.

Walter H. H. H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66-00604 66 00750		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00750	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Strein, Baby Boy		2. DATE AND HOUR OF DEATH 1/8/66 11 ²⁰ P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 53-00		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Bacto.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 Sinai Hospital of Balto., Inc.		D. STREET ADDRESS (If rural, give location) 602 Walker Ave			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never married	8. DATE OF BIRTH 1/7/66	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Md	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Carl Strein		14. MOTHER'S MAIDEN NAME Barbara Meincke			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 773.51 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Respiratory distress DUE TO (B) Prematurity (31 weeks gestation) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ① Intestinal obstruction - prob. duodenal ② Poss Down's Syndrome					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 1/7/66 to 1/8/66, that (H) (we) last saw the deceased alive on 1/5/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sidney Seidman		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/8/66	
23C. PHYSICIAN'S NAME (Type) Sidney Seidman		23D. ADDRESS Sinai Hosp. Balto.			
24A. BURIAL CREMATION, REMOVAL (Specify) JAN 24 1966		24B. DATE JAN 24 1966		24C. NAME OF CEMETERY UNIVERSITY MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR R. E. F. F. F.		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BOND	

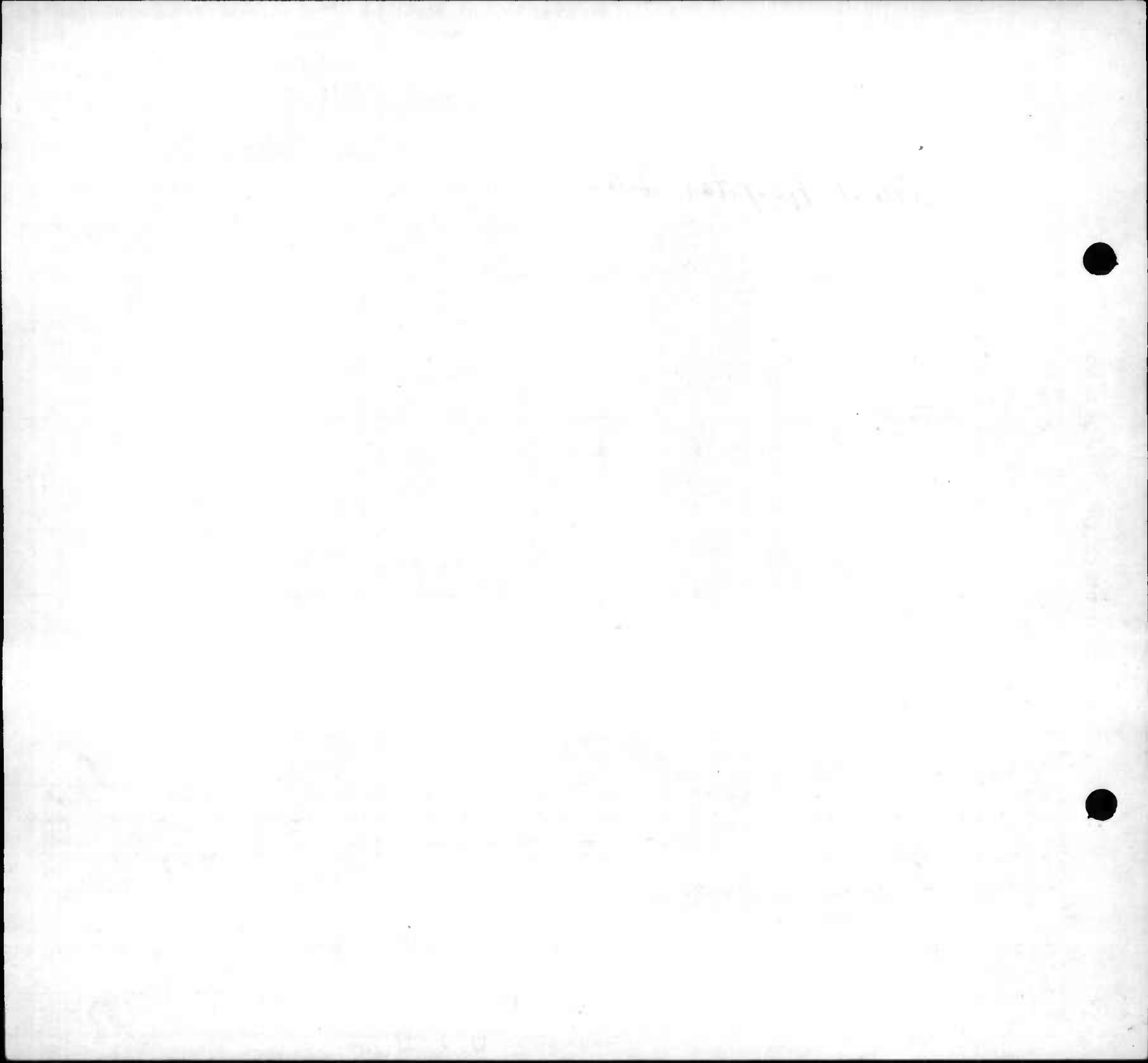


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <u>86 00751</u>				
BIRTH NO. <u>66-0151086 00751</u>									
M.E. CASE NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) <u>Mills, Baby Boy</u>					1/14/66 2:05 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>H Sinai Hospital INC.</u>					A. STATE <u>Md.</u>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto</u>				
					D. STREET ADDRESS (If rural, give location) <u>3226 Sequoia Ave</u>				
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>never married</u>		8. DATE OF BIRTH <u>1/3/66</u>	9. AGE (In years last birthday)		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Theodie Miller</u>					14. MOTHER'S MAIDEN NAME <u>Jean Wright</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>not No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory distress Syndrome</u> <u>Prematurity (35 weeks gestation)</u> <u>Erythroblastosis fetalis</u>					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?					
22. I certify that (s) (this hospital) attended the deceased from <u>1/13/</u> 19 <u>66</u> to <u>1/14/</u> 19 <u>66</u> , that (s) (we) last saw the deceased alive on <u>1/16/</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.									
23A. SIGNATURE <u>Sidney Seidman</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>1/16/66</u>	
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS <u>Sinai Hosp. & Balto</u>				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>JAN 24 1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>ANATOMY BOARD OF MARYLAND</u>		24D. LOCATION (City, town, or State) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 24 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Seidman</u>							

UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BALTO



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66-00809 66 00752				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 00752	
M.E. CASE NO.				1. NAME OF DECEASED (Type of birth)		2. DATE AND HOUR OF DEATH		M.	
(B) Male				Amel Farb		11-7-66		4:05	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION				(If not in hospital or institution, give street address or location)		Maryland		Baltimore	
H2 Sinai Hosp. of Balto., Inc.						C. CITY OR TOWN		(If outside city limits, write RURAL and give township)	
						Baltimore		5300	
D. STREET ADDRESS				(If rural, give location)		894 Maplebrook Rd.			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)	
M		W				11/7/66		1	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
						Baltimore Md.		US	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
David Amel Farb				Geraldine German					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. 774 X I				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMATURITY - 24 WEEKS					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(B) DUE TO					
ANTECEDENT CAUSES				(C) TRIPLET GESTATION					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
2				✓					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
Raymond B. Goldberger				11/8/66					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
Raymond B. Goldberger				3806 Fallstaff Rd. Balto. 15 Md.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, and county) (State)			
		JAN 24 1966		ANATOMY BOARD OF MARYLAND					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS			
JAN 24 1966		E. J. ...		UNIVERSITY MEDICAL SCHOOL					
MORTUARY SERVICE - BCHD									

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66-00810 66 00753				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 00753	
M.E. CASE NO.				1. NAME OF DECEASED (Type as Print) <i>Male Humei Farb</i>		2. DATE AND HOUR OF DEATH <i>1/7/66 403pm</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE <i>Maryland</i>		B. COUNTY <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>1 Sinai Hospital of Baltimore</i>				(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		D. STREET ADDRESS (If rural, give location) <i>894 Maplebrook Rd</i>	
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <i>1/7/66</i>	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>David Humei Farb</i>				14. MOTHER'S MAIDEN NAME <i>Geraldine German</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. <i>723.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>IMMATURITY - MY WIZARDS</i> DUE TO (B) <i>TRIPLET GESTATION</i> DUE TO (C) <i>POLYHYDRAMNIOS</i>				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> , that (I) (we) lost saw the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Raymond B. Goldberg</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>1/8/66</i>			
23C. PHYSICIAN'S NAME (Type) <i>Raymond B. Goldberg</i>				23D. ADDRESS M.D. <i>3806 Fairview Rd Baltimore MD</i>					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>JAN 24 1966</i>		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 24 1966</i>		25B. NAME OF REGISTRAR <i>John F. ...</i>		25C. FUNERAL DIRECTOR <i>UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD</i>		ADDRESS			

I am sorry to hear
of your illness

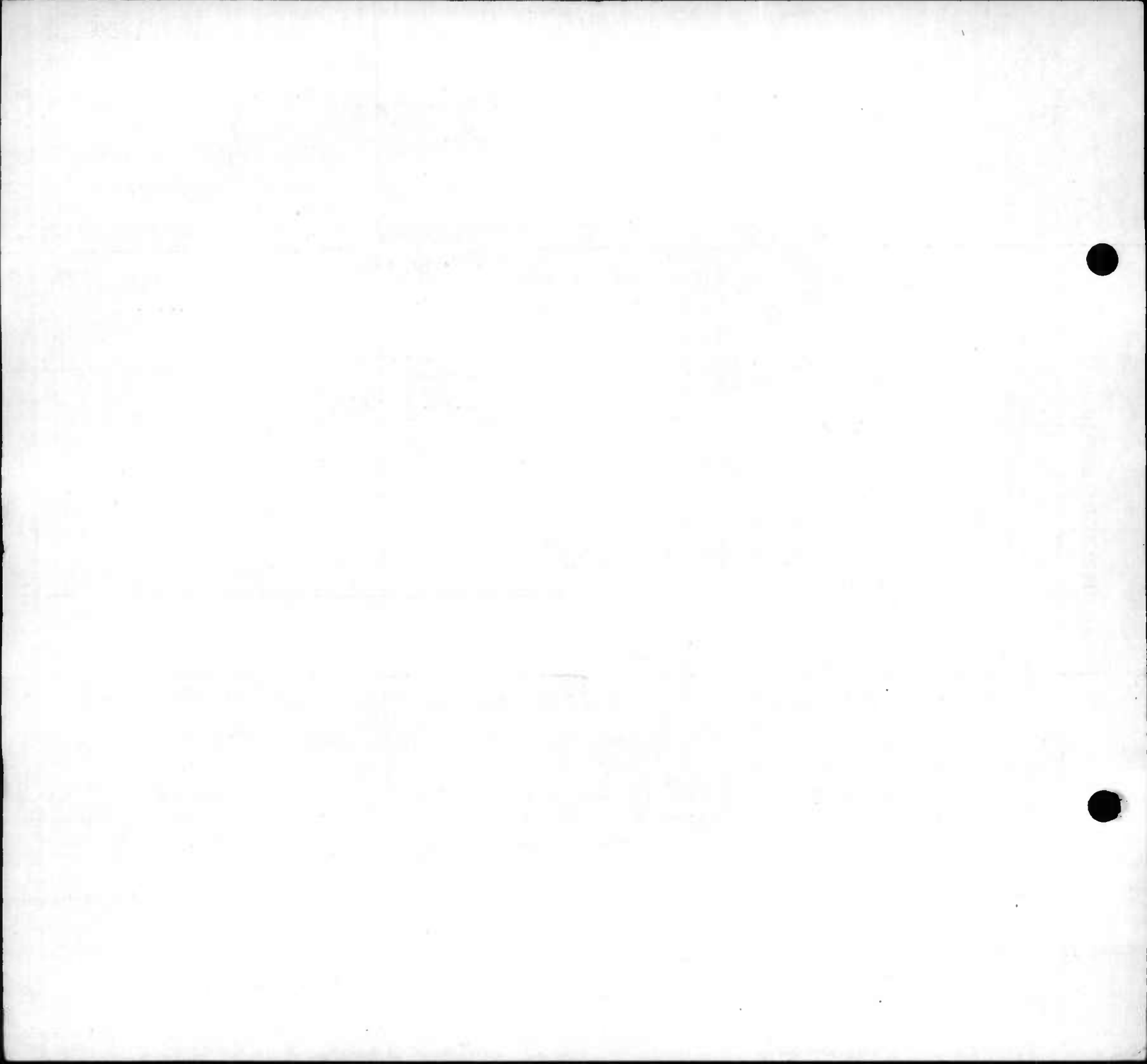
Dear Mother

My dear Mother
I am sorry to hear
of your illness

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

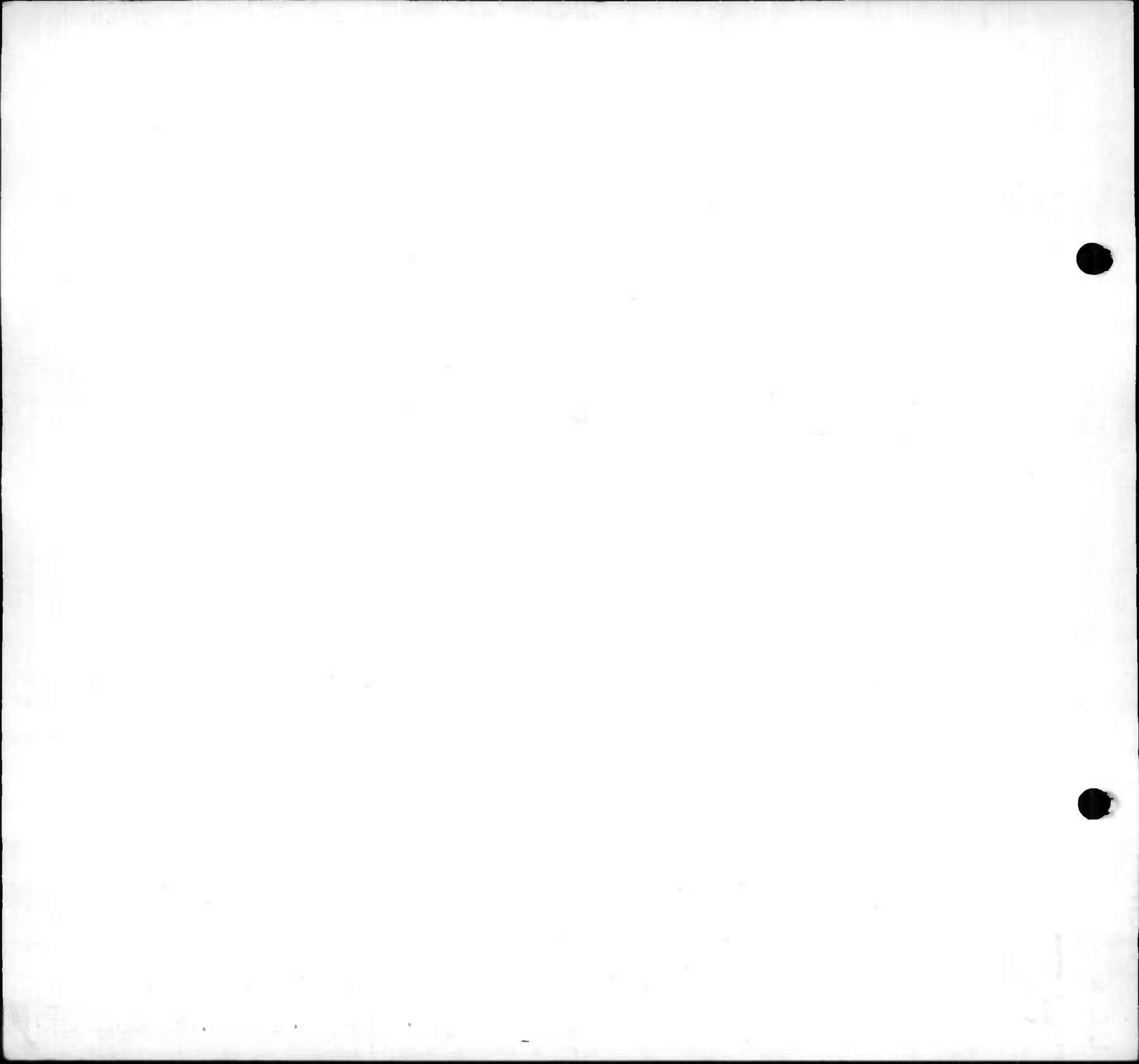
BALTIMORE CITY HEALTH DEPARTMENT						Registered No. 66 00754	
BIRTH NO. 66 00754						CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) MARY E. BORLEIS						2. DATE AND HOUR OF DEATH 20 Jan. 1966 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Harford Gardens Nursing Home						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2601	
5. SEX Female 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed						8. DATE OF BIRTH Jan. 22, 1882 9. AGE (In years last birthday) 83	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home						11. BIRTHPLACE (State or foreign country) Maryland	
10B. KIND OF BUSINESS OR INDUSTRY						12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George L. Nagler						14. MOTHER'S MAIDEN NAME Mary Foster	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no						16. SOCIAL SECURITY NO.	
17. INFORMANT Carl W. Borleis						ADDRESS 5747 B Hazelwood Ave	
18. 230X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						CAUSE OF DEATH (A) Bladder Tumor & Hemorrhage DUE TO	
						(B) _____ DUE TO	
						(C) _____ DUE TO	
						INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION						19A. DATE OF OPERATION	
						19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
						20A. AUTOPSY? (Yes or No) No	
						20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)						21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)						21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from Jan 19 30 to Jan 20 1966 , that (I) (we) last saw the deceased alive on Jan 20 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Louis Krause						23B. DATE SIGNED 1/23/66	
23C. PHYSICIAN'S NAME (Type) Louis A. M. Krause						23D. ADDRESS 11 E. Chase St.	
24A. BURIAL CREMATION, REMOVAL (Specify) burial						24B. DATE 1-24-66	
24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery						24D. LOCATION (City, town, or county) (State) Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966						25B. NAME OF REGISTRAR Ullrich Funeral Home, Baltimore, Md.	
25C. FUNERAL DIRECTOR						ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 25-37-01 C GU									
66 00755									
BIRTH NO.									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
Thomas Fitzgerald					January 21, 1966 9 ³⁰ P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY				
University Hospital					Maryland 26-08				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					Baltimore				
					D. STREET ADDRESS (If rural, give location)				
					3438 Leverton Avenue				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
Male	Caucasian	Married		12-22-94	71				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Tool Maker Retired			Martin Company		Maryland		USA		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Thomas P. Fitzgerald					Winona Boone				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
Yes WW I					216-09-5252		Chart		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) Pulmonary Infarct				
ANTECEDENT CAUSES					(B) Benign Prostatic Hypertrophy				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C) Acute Urinary Retention				
INTERVAL BETWEEN ONSET AND DEATH					1 hr				
3 years					3 days				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
Jan 20, 1966			Benign Prostatic Hypertrophy		No				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?				
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						
22. I certify that (I) (this hospital) attended the deceased from Jan 18 1966 to Jan 21 1966, that (I) (we) last saw the deceased alive on Jan 21 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED	
Ralph M. Howard								Jan 21, 1966	
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
Ralph M. Howard					Dept. of Urology University Hosp. Balto. Md.				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		1/25/1966		Baltimore Cemetery		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR			ADDRESS	
JAN 24 1966			R. E. F. B. F. B. F. B.		John A. Moran, Inc.			3000 E. Baltimore St.	



66 00756

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 00756

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

THOMAS E. MURPHY

2. DATE AND HOUR PRONOUNCED DEAD

January 20, 1966 3:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2718 E. Fairmount Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2718 E. Fairmount Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

widowed

8. DATE OF BIRTH

May 23, 1898

9. AGE (In years
last birthday)

67

10. Under 1 Yr. 11 Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Auto Mechanic (retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Michael Murphy

14. MOTHER'S MAIDEN NAME

Sarah McCourt

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

USA yes

WWI

16. SOCIAL
SECURITY NO.

215-07-3915

17. INFORMANT

ADDRESS

Thomas Murphy 306 Baylor Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular
DUE TO diseases

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

6

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-20-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1/24/66

23C. NAME OF CEMETERY or CREMATORY

Oak Lawn Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JAN 24 1966

24B. NAME OF REGISTRAR

John A. Moran, Inc.

24C. FUNERAL DIRECTOR

John A. Moran, Inc. 3000 E. Balto. St

VALLEY FORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00757	
BIRTH NO. 66 00757				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MILLER, LOUIS VOGEL		2. DATE AND HOUR OF DEATH JANUARY 22, 1966 9:00 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 26-10		5. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 24	
FULL NAME OF HOSPITAL OR INSTITUTION NORTH CHARLES GEN. HOSPITAL		6. STREET ADDRESS (If rural, give location) 3300 E. BALTIMORE STREET		7. CITIZEN OF WHAT COUNTRY? U.S.A.	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 6-3-1902	9. AGE (In years last birthday) 63	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF-EMPLOYED		10B. KIND OF BUSINESS OR INDUSTRY RETAIL HARDWARE		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME CONRAD MILLER		14. MOTHER'S MAIDEN NAME EMMA D. Zauder		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 213-03-4576		17. INFORMANT LOUISE MILLER (WIFE)		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarct - 2ds.		CAUSE OF DEATH (A) DUE TO atherosclerotic heart dis.		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Myocardial hypertrophy		(B) DUE TO		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that W (this hospital) attended the deceased from January 20 19 66 to January 22 19 66 , that W (we) last saw the deceased alive on January 22 19 66 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. W (We) (did) not view the body after death.					
23A. SIGNATURE M. Feldman		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED January 22, 1966	
23C. PHYSICIAN'S NAME (Type) M. FELDMAN		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/25/1966		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966			
25B. NAME OF REGISTRAR John A. Moran Inc.		25C. FUNERAL DIRECTOR ADDRESS 3000 E. Baltimore St.			

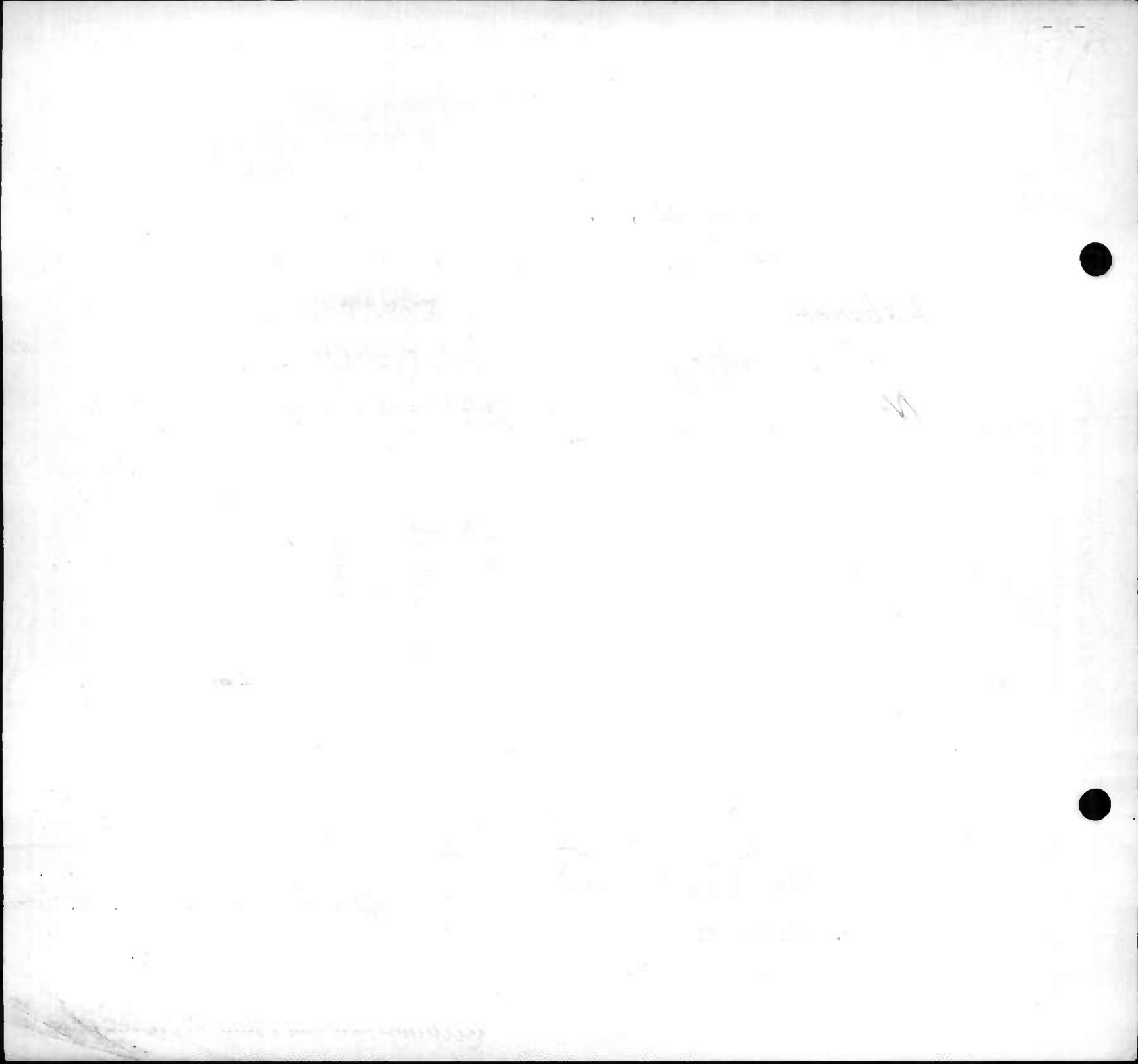
Went to the
theater to see
the play

35-38-29
FR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

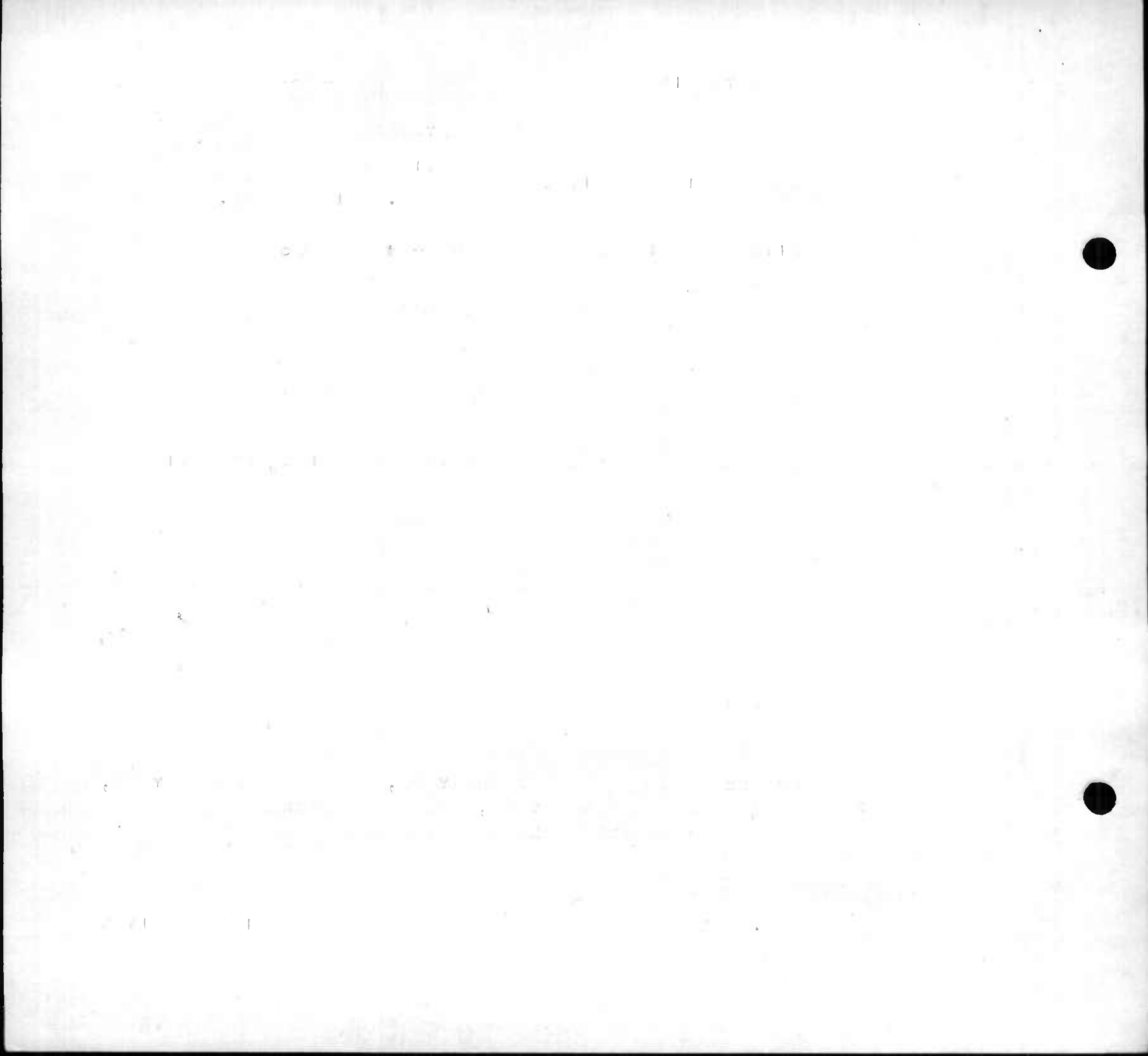
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 00758	
M.E. CASE NO. 66 00758				1. NAME OF DECEASED (Type or Print) JAMES LOCKLEY			
2. DATE AND HOUR OF DEATH 1-21-66 9 ⁰⁰ A. M.				3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY Hosp. 4940 Eastern Avenue Balto, Md. 21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1103 W. MULBERRY ST. 18-02			
5. SEX M		6. RACE Negro		7. MARRIED (NEVER MARRIED) WIDOWED, DIVORCED, etc. (Specify) Married - 8 yrs.		8. DATE OF BIRTH 1-11-08 58	
9. AGE (In years last birthday) 58		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Matthews Co. Va.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Rufus Lockley		14. MOTHER'S MAIDEN NAME Mittie Dennis		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS: BCH 4940 Eastern Avenue 21224		18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) PNEUMONIA		3 days.			
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Hepatic Coma		8 days.			
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Hepatic Cirrhosis		10 years.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 8-12-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Repetitive Coma		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 1-14 1965 to 1-21 1966, that (2) (we) last saw the deceased alive on 1-21-66 19 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. Randall				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-21-66	
23C. PHYSICIAN'S NAME (Type) Dr. John Randall				M.D. 23D. ADDRESS 4940 Eastern Avenue, Balto. Md. 21224 Balto City Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/26/1966		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem. Balto. Md.		24D. LOCATION (City, town or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR R. J. E. Talbot		25C. FUNERAL DIRECTOR Williams General Home 3197 Scholten St		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

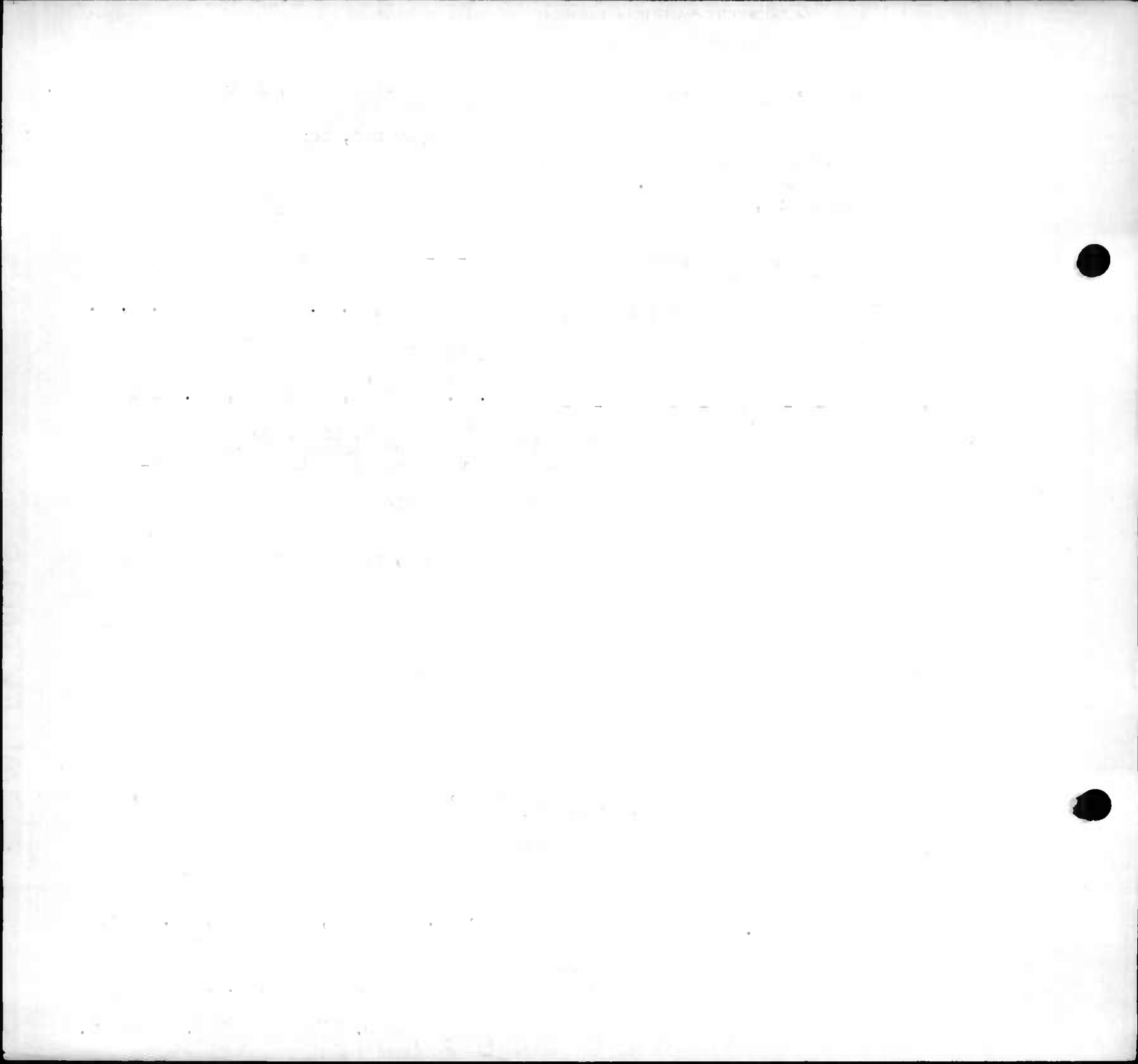
BIRTH NO. 66 00759				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00759	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MARY L. PIRRERA				2. DATE AND HOUR OF DEATH 1-19-66 9:17 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 6-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 202 N. MILTON AVE.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 2-25-99	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ALTERATION		10B. KIND OF BUSINESS OR INDUSTRY TAILORING		11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PETER PAUL LANA			14. MOTHER'S MAIDEN NAME SALVATRICE GRAFFAGNINO				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. -		17. INFORMANT Mrs. Rachel Calcare - 202 N. Milton Ave.		
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from JANUARY 17, 1966 to JANUARY 19, 1966 , that (I) (we) last saw the deceased alive on JANUARY 19, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.							
23A. SIGNATURE Herman K. Gold				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) HERMAN K. GOLD				23D. ADDRESS M.D. THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-22-66		24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER CEM.		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR Robert E. Talley		25C. FUNERAL DIRECTOR Harold Miller		ADDRESS 2334 Jefferson St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 00760</u>	
BIRTH NO. <u>66 00760</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>RITTER, WILMON (NMI)</u>		2. DATE AND HOUR OF DEATH <u>JANUARY 22, 1966</u> <u>4:15 A.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Pennsylvania, York</u> B. COUNTY <u>V-35</u>			
FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Veterans Administration Hospital</u> <u>3900 Loch Raven Blvd.</u> <u>Baltimore, Maryland 21218</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>York</u>			
		D. STREET ADDRESS (If rural, give location) <u>138 Newberry Street</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>5-25-94</u>	9. AGE (In years last birthday) <u>70</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Allendale, S. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Jose Ritter</u>		14. MOTHER'S MAIDEN NAME <u>Ella Brabham</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>7-18-18 to 1-18-19</u>		16. SOCIAL SECURITY NO. <u>164-28-6573</u>		17. INFORMANT <u>Records</u> ADDRESS <u>V. A. Hospital, Baltimore, Md. 21218</u>	
18. <u>002,11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Empyema, right lung with compression atelectasis and severe pulmonary fibrosis</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 Years</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO <u>Arteriosclerotic heart disease</u>		<u>Many Years</u>	
		(B) DUE TO <u>Pyelonephritis, chronic</u>		<u>Many Years</u>	
		(C) <u>Pulmonary tuberculosis</u>		<u>Many Years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>May 5, 1964</u> to <u>January 22, 1966</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>January 22, 1966</u> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (did not) view the body after death.					
23A. SIGNATURE <u>Anna R. Berky</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1/22/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Anna R. Berky</u>		23D. ADDRESS <u>V. A. Hospital, Baltimore, Md. 21218</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		24B. DATE <u>1-23-1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>Three Mile Creek Christian</u>	
24D. LOCATION (City, town, or county) (State) <u>Allendale, S.C.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 24 1966</u>		25B. NAME OF REGISTRAR <u>R. E. Falkner</u>		25C. FUNERAL DIRECTOR <u>Arlington S. Phillips 1727 N. Monroe St.</u>	



A 450

66 00761

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 00761

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

William Allen

(HENRY)

2. DATE AND HOUR PRONOUNCED DEAD

Jan. 22. 1966

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)2137 Division St.
Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2137 Division Street

14-03

5. SEX

M.

6. RACE

C.

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

6-16-1904

9. AGE (In years
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Machinist

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

William A. Allen Sr.

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

220-075692

17. INFORMANT

ADDRESS

Rosa E. Allen 2137 Division St.

18.

422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO Arteriosclerotic cardiovascular

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO Disease

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/23/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

1/24/66

23C. NAME of CEMETERY or CREMATORY

Ashburton Mem. Sh. Baltimore Md.

23D. LOCATION (City, town, or county)

Md.

24A. DATE REC'D BY HEALTH DEPT.

JAN 24 1966

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Arlington S. Phillips 1727 N. Mount St.

ADDRESS

EDUCATION DEPARTMENT
WASHINGTON, D. C.
May 10, 1904

W. A. R. L. V. A. P.
To the Honorable
Commissioner of Education
New York City
New York
Dear Sir:
I have the honor to acknowledge the receipt of your letter of the 4th inst. in relation to the above named subject.

It is the policy of the Department to encourage the study of the history of the United States in the schools of this country. It is the hope of the Department that the study of the history of the United States will be made a part of the curriculum of the schools of this country.

Very respectfully,
John D. Phillips
Director

66 00762

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 00762

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROBERT MATIER

2. DATE AND HOUR PRONOUNCED DEAD

Jan. 22/ 1966

2.25 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

PROVIDENT HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1313 Harlem Avenue

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

2 - 17 - 1939

9. AGE (In years
lost birthday)

26

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

David Matier

14. MOTHER'S MAIDEN NAME

Callie Rudd

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

237.62-0017

17. INFORMANT

ADDRESS

Gloria Faith 701 W. Mulberry St.

18.

E981X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Gross Gunshot wound of chest, involving

aorta and left lung

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

in home

21C. WHERE DID (If in Baltimore City, give exact location)

INJURY OCCUR? 1313 Harlem Avenue, Baltimore

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

Jan. 22 66 2004

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

shot by common law wife

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREWerner U. Spitz, M.D.
EXAMINER'S NAME (Type)

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Jan. 22/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1/26/66

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

Baltimore

(State)

MD.

24A. DATE REC'D BY HEALTH DEPT.

JAN 24 1966

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Arlington Phillips 1727 N. Mount

ADDRESS

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

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1
L530

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

65-29301

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

66 00763

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MICHELLE LINDY

2. DATE AND HOUR PRONOUNCED DEAD

January 19, 1966

11:25 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BON SECOURS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2616 W. Lexington Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

never married

8. DATE OF BIRTH

11/19/65

9. AGE (In years
last birthday)

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

2

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Lindy

14. MOTHER'S MAIDEN NAME

Carolyn Pinkard

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Carolyn P. Lindy 2616 W. Lexington ST.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Interstitial pneumonitis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

21D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK

NOT WHILE AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-20-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1/22/66

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

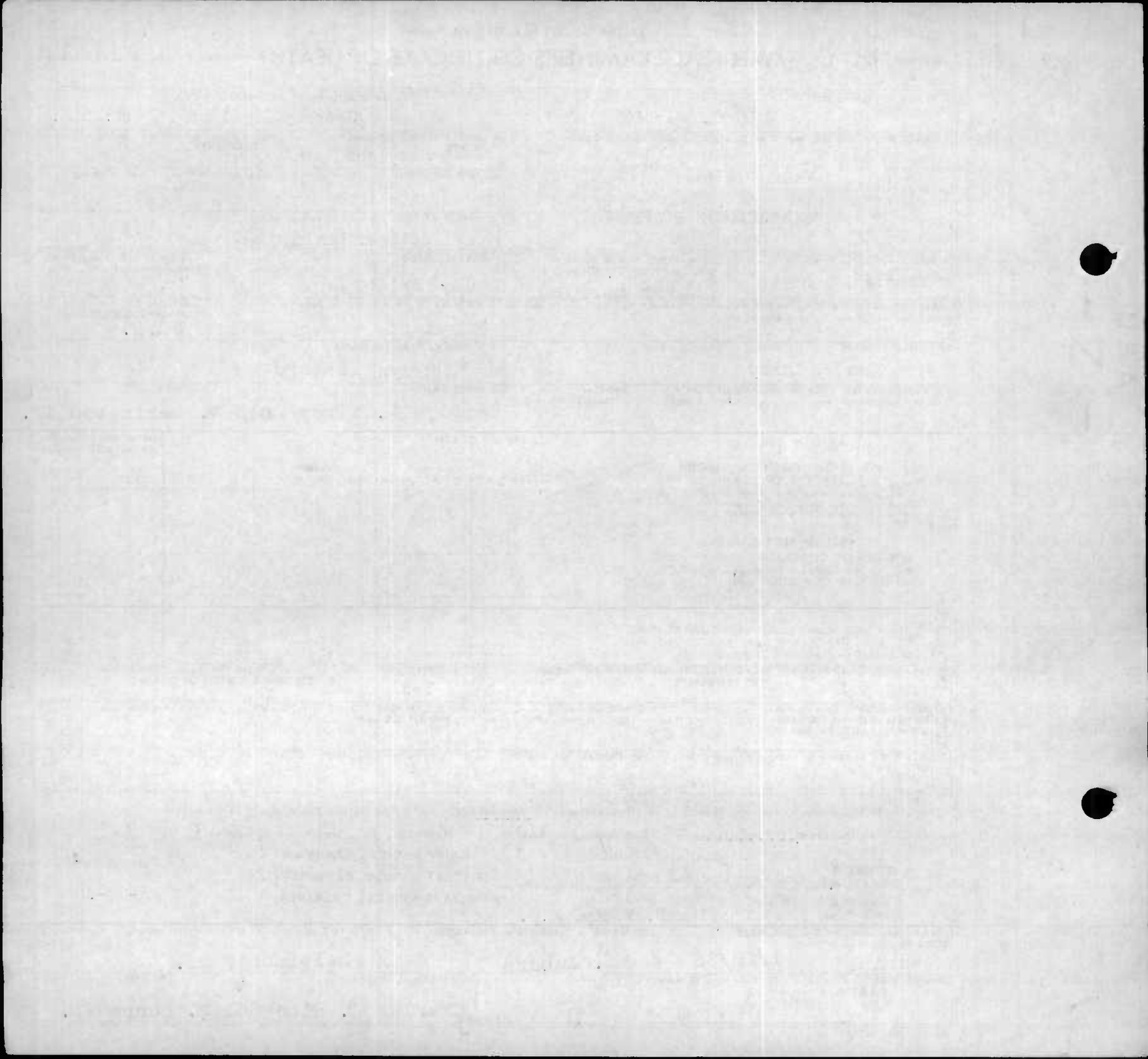
24C. FUNERAL DIRECTOR

ADDRESS

JAN 24 1966

Charles A. Rice

Charles A. Rice 661 W. Barre St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				GREEN. PRICE	
CERTIFICATE OF DEATH				Registered No. 66 00764	
BIRTH NO. 650 M.E. CASE NO. 66 00764		1. NAME OF DECEASED (Type or Print) Price Green			
2. DATE AND HOUR OF DEATH 1-18-66 6:00 am.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 5-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 11 North Exeter Street		5. SEX Male 6. RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married			
8. DATE OF BIRTH 1-22-18 9. AGE (In years last birthday) 47		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Price Green		14. MOTHER'S MAIDEN NAME Daisy Joyce			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mary Price 11 N-Exeter St ADDRESS	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Myocardial infarction DUE TO (B) HASCVD (C)		INTERVAL BETWEEN ONSET AND DEATH 2 HRS 10 YRS	
19. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) XXX NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/18 19 66 to 1/18 19 66, that (I) (we) last saw the deceased alive on 1/18 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J.R. Spencer M.O. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED XXXXXX 1-18-66	
23C. PHYSICIAN'S NAME (Type) J.R. SPENCER M.D.				23D. ADDRESS Johns Hopkins Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE		24C. NAME of CEMETERY or CREMATORY Madison	
24D. LOCATION (City, town, or county) Madison		(State) N.C.			
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR Charles E. Farley		25C. FUNERAL DIRECTOR Charles A. Rice ADDRESS	

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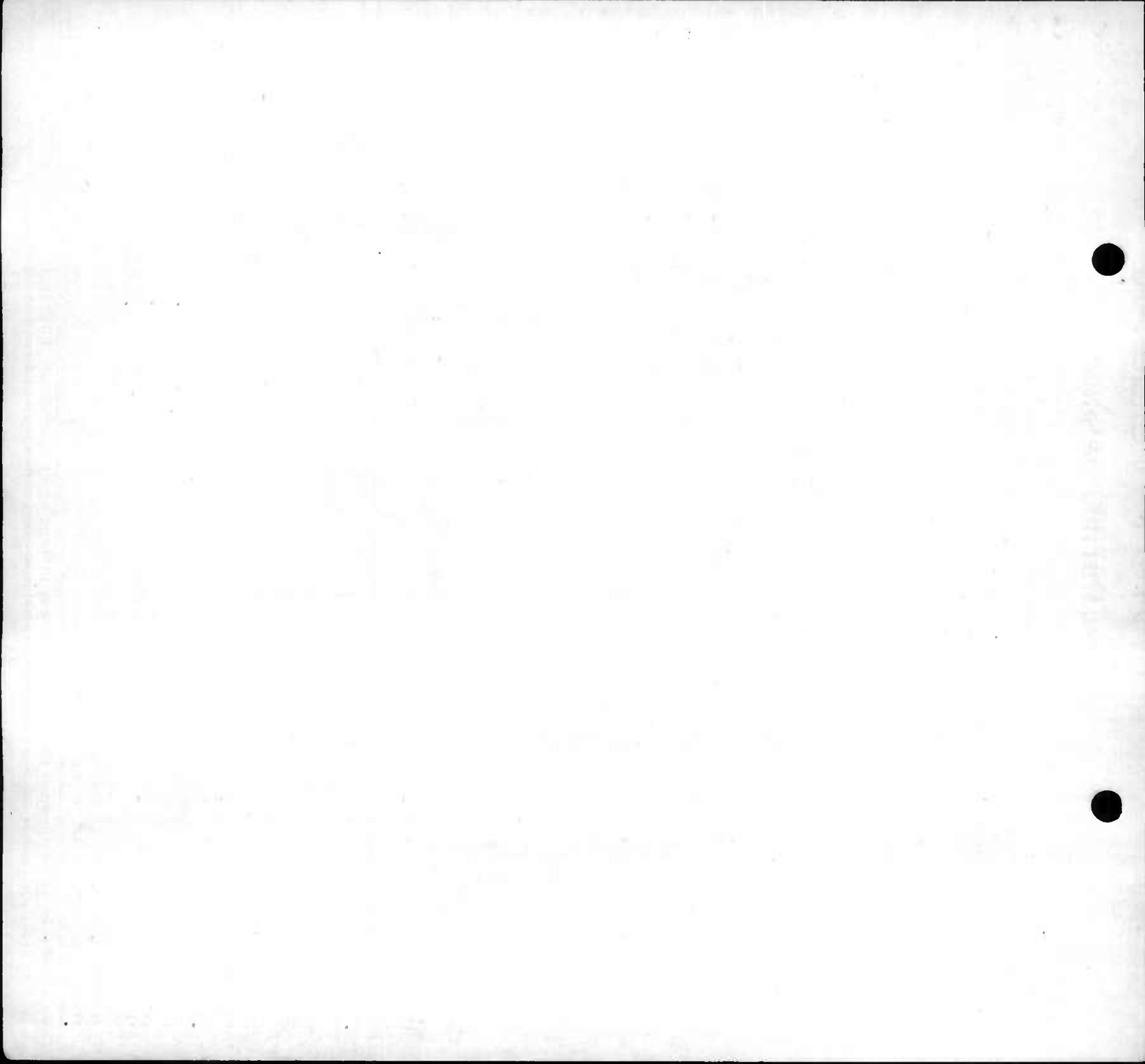
Handwritten mark or character, possibly a stylized letter or symbol.

Handwritten text at the bottom left, possibly a date or reference number.

Handwritten text at the bottom right, possibly a signature or name.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

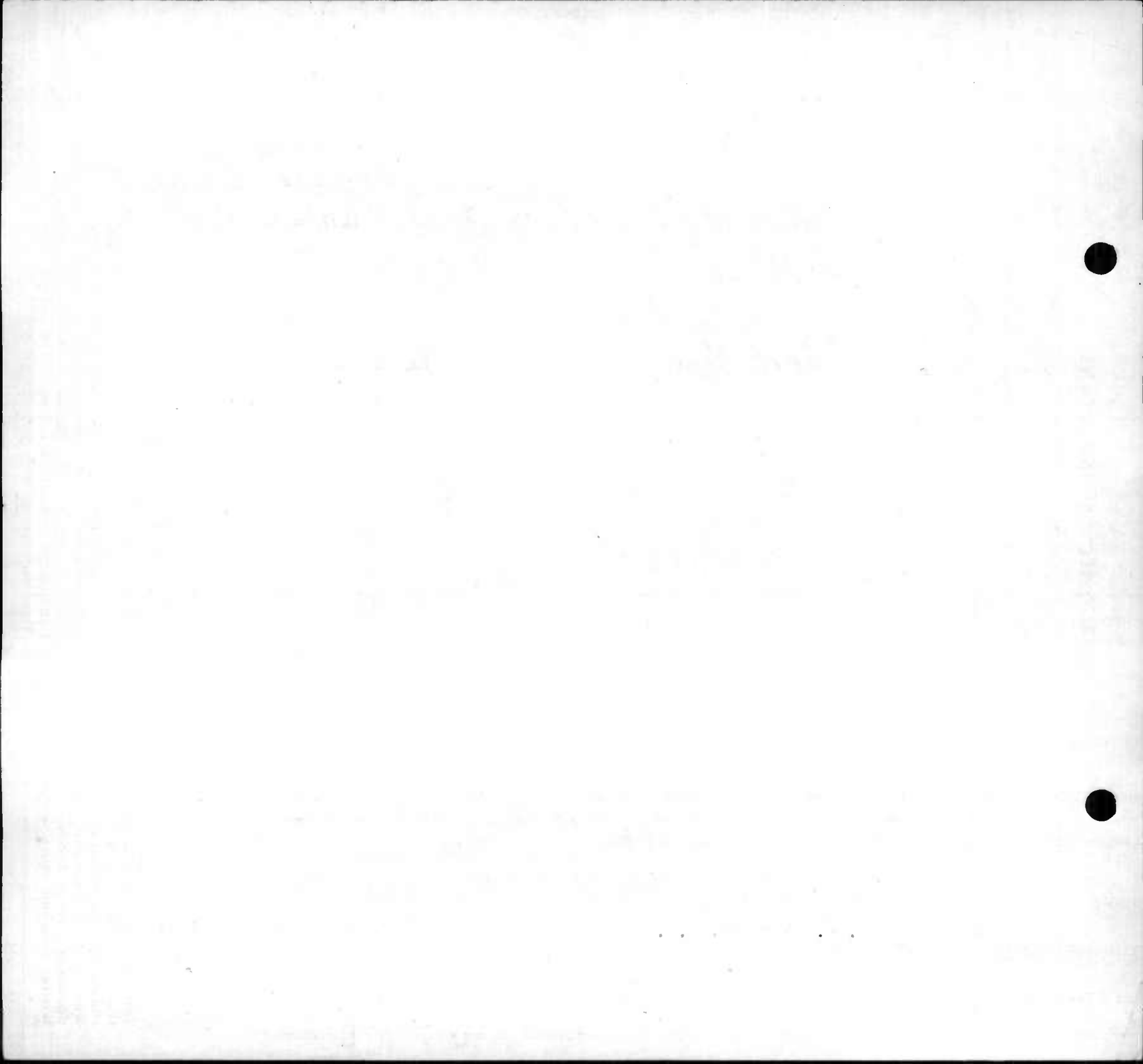
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>66 00765</u>	
BIRTH NO. <u>66 00765</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Annie Mae White</u>		2. DATE AND HOUR OF DEATH <u>January 21, 1966</u> <u>12:10p</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland 21217</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>17-01</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>650 George Street</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>1914</u>		9. AGE (In years last birthday) <u>51</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u> <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> <u>unknown</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-48-5876</u>		17. INFORMANT <u>Oliver Fryson-brother</u> Phone: <u>566 4487</u>		ADDRESS <u>832 W. Vine Street</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cerebro. Vascular</u> <u>Accident</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>January 12, 1966</u> to <u>January 21, 1966</u> , that (I) (we) last saw the deceased alive on <u>January 21, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>R. Theodore</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>January 21, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>Roger Theodore</u>				23D. ADDRESS M.D. <u>1514 Division Street - Baltimore 17, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/27/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Summerton</u>		24D. LOCATION (City, town, or county) (State) <u>South Carolina</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 24 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Sisk</u>		25C. FUNERAL DIRECTOR <u>Charles A. Rice</u> ADDRESS <u>661 W. Barre St.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 00766</u>	
BIRTH NO. <u>66 00766</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Carrie Young</u>			
2. DATE AND HOUR OF DEATH <u>1-19-66</u> <u>5:25 P.M.</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hosp.</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> #21225			
		D. STREET ADDRESS (If rural, give location) <u>3408 Sunlea Ct. 25-06</u>			
5. SEX <u>F.</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>S</u>	8. DATE OF BIRTH <u>12-8-87</u>	9. AGE (In years last birthday) <u>78</u>	10. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
13. FATHER'S NAME <u>Robert Young</u>			14. MOTHER'S MAIDEN NAME <u>Jane Weaver.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-38-059</u>		17. INFORMANT <u>Anna M. Starke</u> ADDRESS <u>1312 W. Saratoga St</u>	
18. <u>451X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Dissecting Thoracic Aneurysm</u> DUE TO (B) <u>ASCVD.</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (the) (this hospital) attended the deceased from <u>1-19</u> 19 <u>66</u> to <u>1-19</u> 19 <u>66</u> , that (we) last saw the deceased alive on <u>1-19</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>H. J. Hargrave</u>				23B. DATE SIGNED <u>1-20-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>H. J. Hargrave, M.D.</u>				23D. ADDRESS <u>South Baltimore General Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/24/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt Auburn</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 24 1966</u>		25B. NAME OF REGISTRAR <u>Charles B. Rice</u>		25C. FUNERAL DIRECTOR <u>Charles B. Rice</u> ADDRESS <u>661 W. Barr St</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 00767					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 66 00767				
1. NAME OF DECEASED (Type or Print) ANNIE PARROTT					2. DATE AND HOUR OF DEATH 1-20-66 2 A. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND 8. COUNTY 8-AD C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1823 N. COLLINGTON AVENUE				
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4-12-15	9. AGE (In years last birthday) 50	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Caroline County Md.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME BUTLER BEELY			14. MOTHER'S MAIDEN NAME SALLY FORGER Fortune			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.			17. INFORMANT Annie Parrott			ADDRESS			
18. 4-20-1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Embolus ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pericarditis(?) Coronary Artery Disease Hypertension					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 1 Hour				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1-16-66 19 to 1-20 1966, that (I) (we) last saw the deceased alive on 1-20 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE M. A. Davis					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-20-66		
23C. PHYSICIAN'S NAME (Type) M. A. DAVIS					23D. ADDRESS THE JOHNS HOPKINS HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/24/66		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem.		24D. LOCATION (City, town, or county) (State) A.A. County Md			
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR M. E. Elickson		25C. FUNERAL DIRECTOR M. E. Elickson		ADDRESS 1129 N. East St.			



44-67-83
FR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 66 00768	
W-300 BIRTH NO. 66 00768		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Walter White		2. DATE AND HOUR OF DEATH January 21, 1966 4:05 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2618 E. Biddle Street 21213			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4-1-1899	9. AGE (In years last birthday) 66	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Interior & Exterior Decorator		11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME George White		14. MOTHER'S MAIDEN NAME Dora		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 217-16-1113			17. INFORMANT RECORDS: BCH 4940 Eastern Avenue 21224		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Pneumonia		19. INTERVAL BETWEEN ONSET AND DEATH 10d
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Adenocarcinoma of Prostate			21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		22. I certify that (I) (this hospital) attended the deceased from Dec 22, 1965 to Jan 21, 1966, that (I) (we) last saw the deceased alive on Jan 21, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23. DATE SIGNED Jan 21, 1966
24. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE JAN 24 1966	24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Arbutus Md.		25. DATE REC'D BY HEALTH DEPT. JAN 24 1966
25A. NAME OF REGISTRAR Robert E. Farber		25B. NAME OF REGISTRAR Special T. E. Jackson		25C. FUNERAL DIRECTOR 1129 N. Calverton St		25D. ADDRESS	

10
Observations

Q

22 Jan 51

Dec 22

Jan 21

Steph

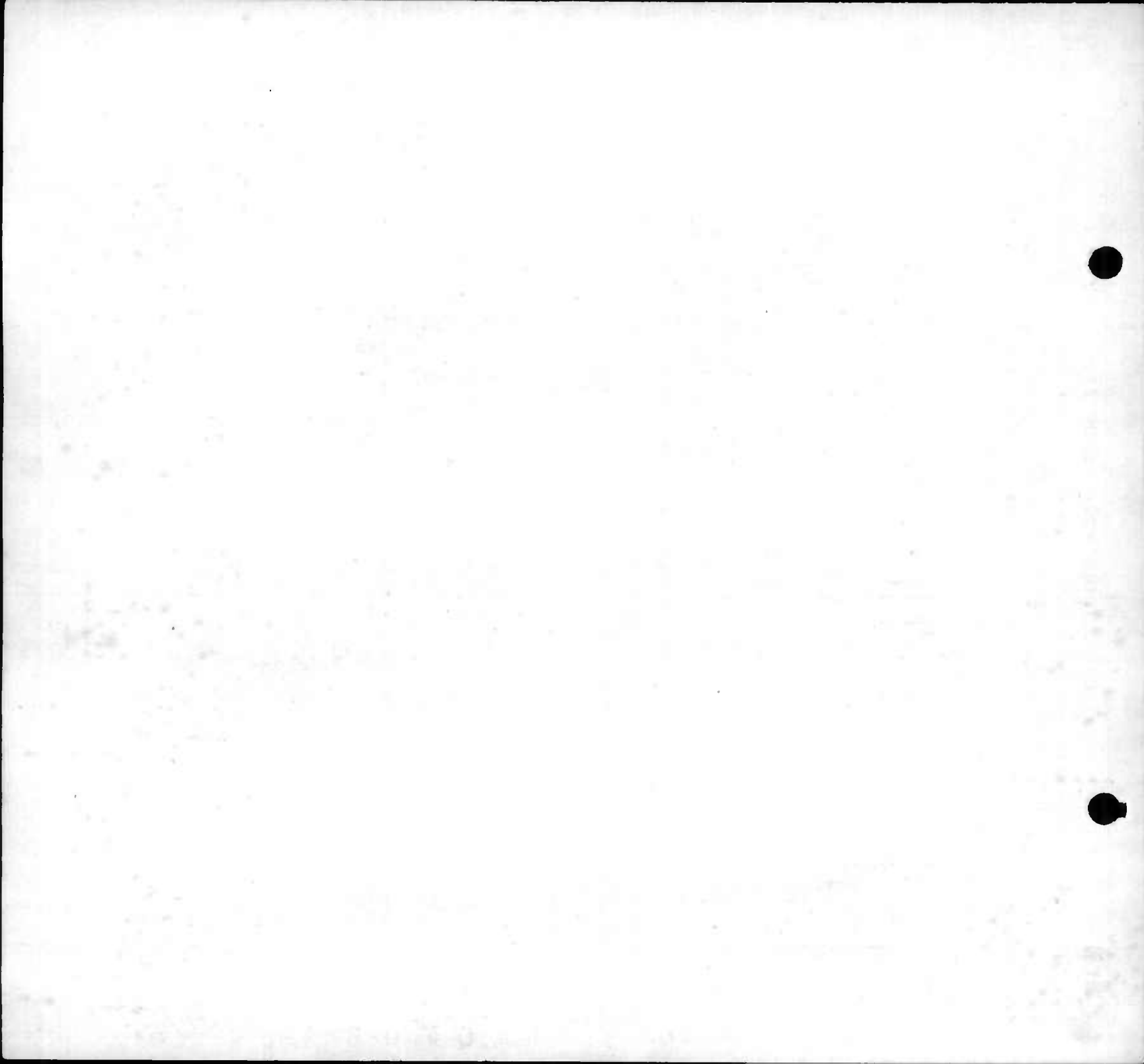
Steph

BCH

FUNERAL DIRECTOR: IMPORTANT

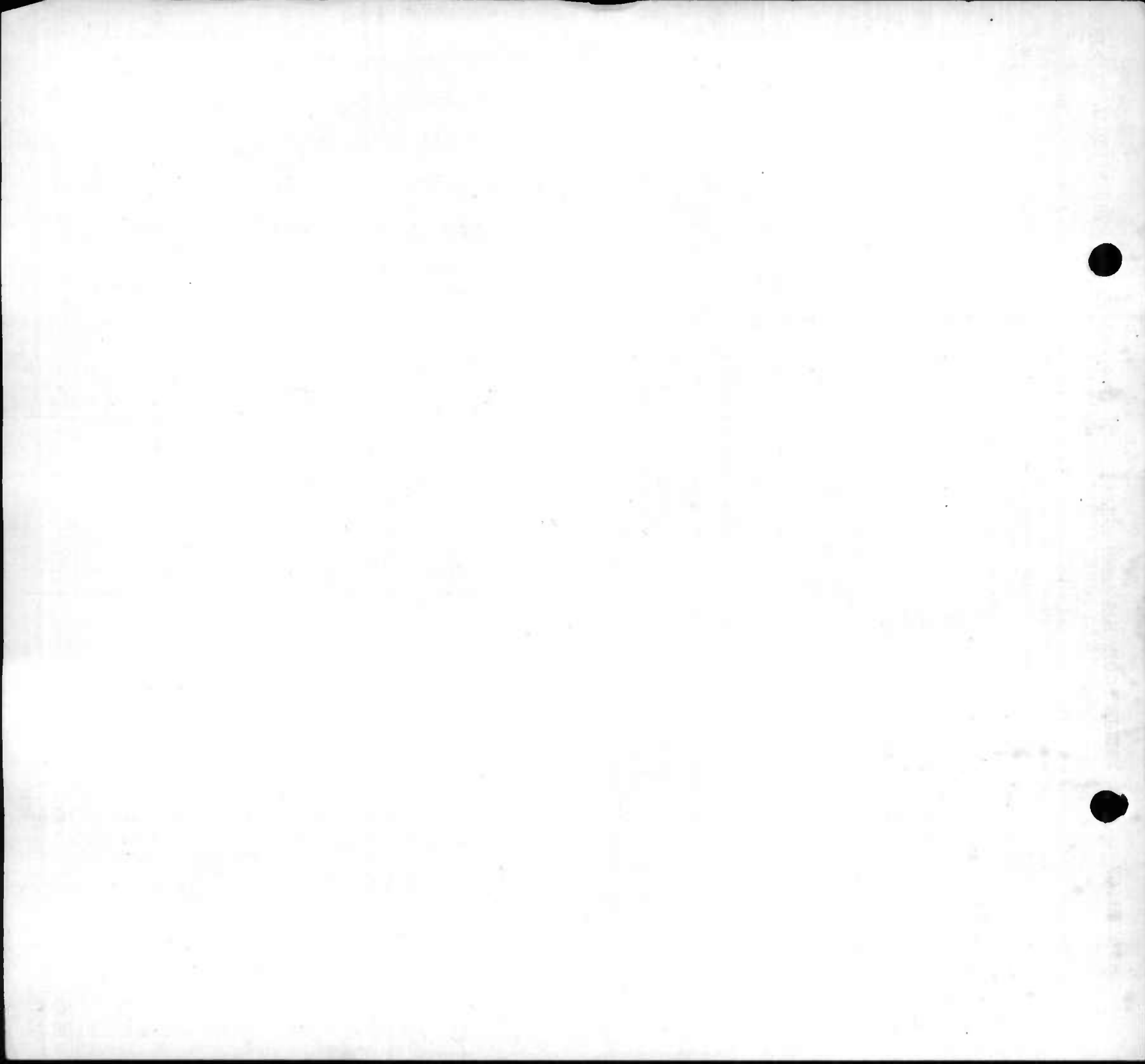
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 00769</u>	
BIRTH NO. <u>66 00769</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <u>January 20, 1966</u> <u>6:15 a</u> M.			
1. NAME OF DECEASED (Type or Print) <u>Banks, Charlie</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Johns Hopkins Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> , B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1243 E. Eager St.</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u>	8. DATE OF BIRTH <u>4-19-98</u>	9. AGE (In years last birthday) <u>67</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Odd jobs.</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Calvin Banks</u>		14. MOTHER'S MAIDEN NAME <u>Rosetta Stokes</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Son</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Uremia</u> DUE TO <u>Unknown</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD, possible cancer, pleural effusion of ? etiology</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from <u>1-18-66</u> 19 <u>66</u> to <u>January 20</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>January 20</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Edgar W. Hull</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>Edgar W. Hull</u>		23D. ADDRESS <u>Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/24/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Bald. Natl Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>5501 Fredrick Cr</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 24 1966</u>		25B. NAME OF REGISTRAR <u>Edgar W. Hull</u>		25C. FUNERAL DIRECTOR <u>Joseph T. Elickson</u>	
				ADDRESS <u>11297 Caroline St</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 5-300 66 00770		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00770	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Mollie Scott			2. DATE AND HOUR OF DEATH 1/20/66 7:07 p.m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital 601 N. Broadway BALTIMORE, Md 21205			A. STATE MARYLAND B. COUNTY 7-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21205 D. STREET ADDRESS (If rural, give location) 912 N. DALLAS STREET		
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5-29-88	9. AGE (In years last birthday) 77	10. AGE (In years last birthday) 77
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) Greenbay Va.		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Bailey Anderson			14. MOTHER'S MAIDEN NAME Ellen Rowlette		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT Edward Scott 912 N. Dallas St			ADDRESS		
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) CANAR CRUUX (B) DUE TO (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Dehydration, Anemia			INTERVAL BETWEEN ONSET AND DEATH 10 mos		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 1/20/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Philip Horowitz			23B. DATE SIGNED 1/20/66		
23C. PHYSICIAN'S NAME (Type) Philip Horowitz			23D. ADDRESS Johns Hopkins Hospital - BALTO - Md		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/25/66		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery A.A. County Md	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Ziggy E. Elickson		25D. ADDRESS 129 N. Central St			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 66 00771					CERTIFICATE OF DEATH		Registered No. 66 00771			
1. NAME OF DECEASED (Type or Print) <i>Lottie Townes</i>					2. DATE AND HOUR OF DEATH <i>JAN 21 / 66</i> <i>A</i> M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>16-01</i>					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>39 Provident Hospital</i>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>					
					D. STREET ADDRESS (If rural, give location) <i>1138 N. Carrollton Ave.</i>					
5. SEX <i>Female</i>	6. RACE <i>Colored</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>5/26/1890</i>	9. AGE (In years last birthday) <i>75</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Sumter S. Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>John Diggs</i>			14. MOTHER'S MAIDEN NAME <i>Theodasia Diggs</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO.			17. INFORMANT <i>Allen Townes</i>			ADDRESS <i>1138 N. Carrollton Ave.</i>				
18. <i>443X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) <i>CARDIO VASCULAR</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>2 YR's</i>			
					(B) <i>HYPERTENSION</i> DUE TO					
					(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (the hospital) attended the deceased from <i>JULY 21</i> 19 <i>65</i> to <i>JAN 21</i> 19 <i>66</i> , that (I) (we) lost saw the deceased alive on <i>DEC 20</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <i>(did)</i> (did not) view the body after death.										
23A. SIGNATURE <i>E. William Frey</i> M.D.						Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>JAN 24 / 66</i>		
23C. PHYSICIAN'S NAME (Type) <i>E WILLIAM FREY</i> M.D.						23D. ADDRESS <i>1928 PENNA AVE 21217</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/25/66</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Prestport (Baltimore) Md.</i>				
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 24 1966</i>			25B. NAME OF REGISTRAR <i>Reuben E. Tolson</i>			25C. FUNERAL DIRECTOR <i>Joseph B. Ross</i>			ADDRESS <i>2222 N. Market Baltimore, Md.</i>	

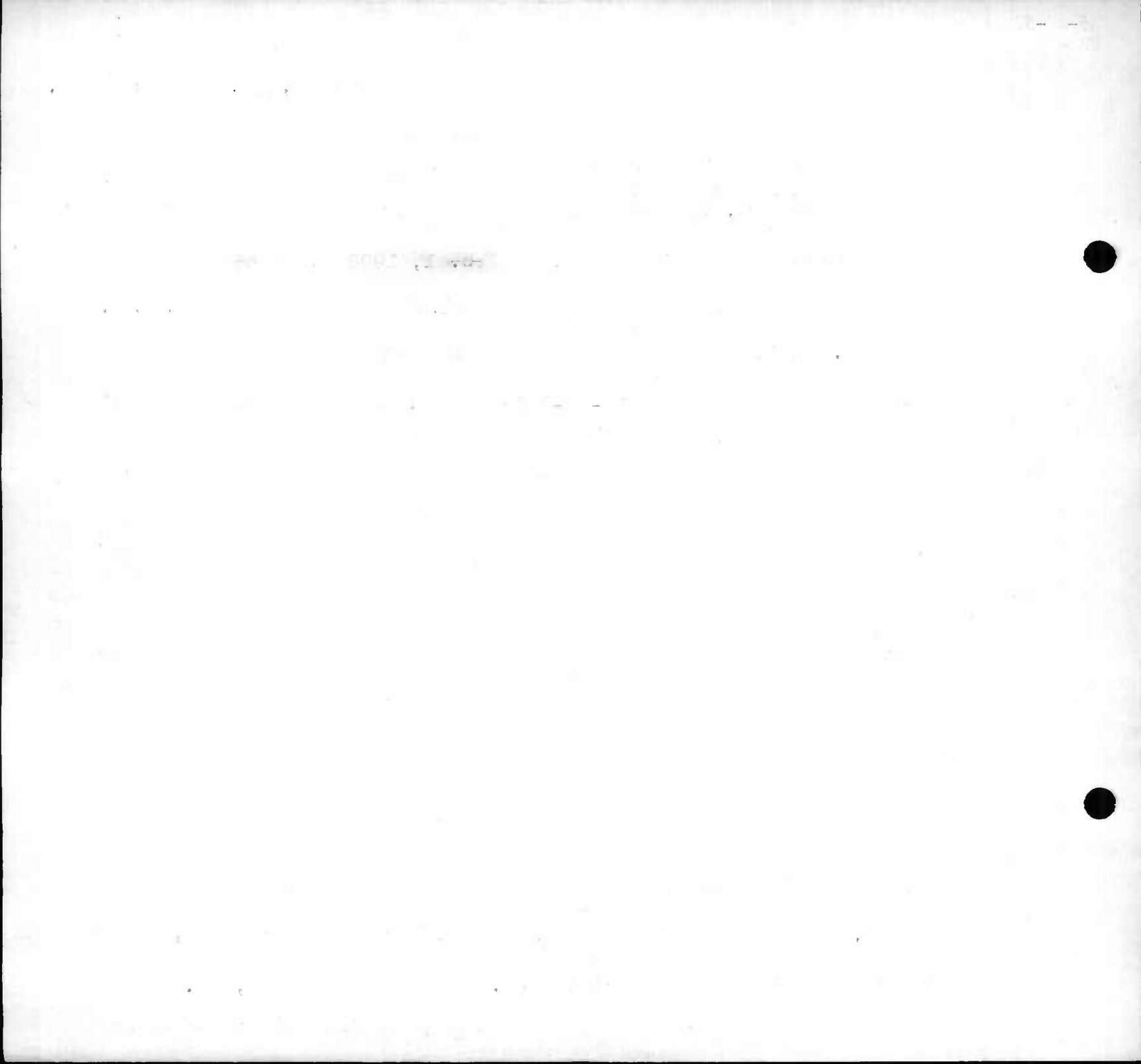
45-49-57

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

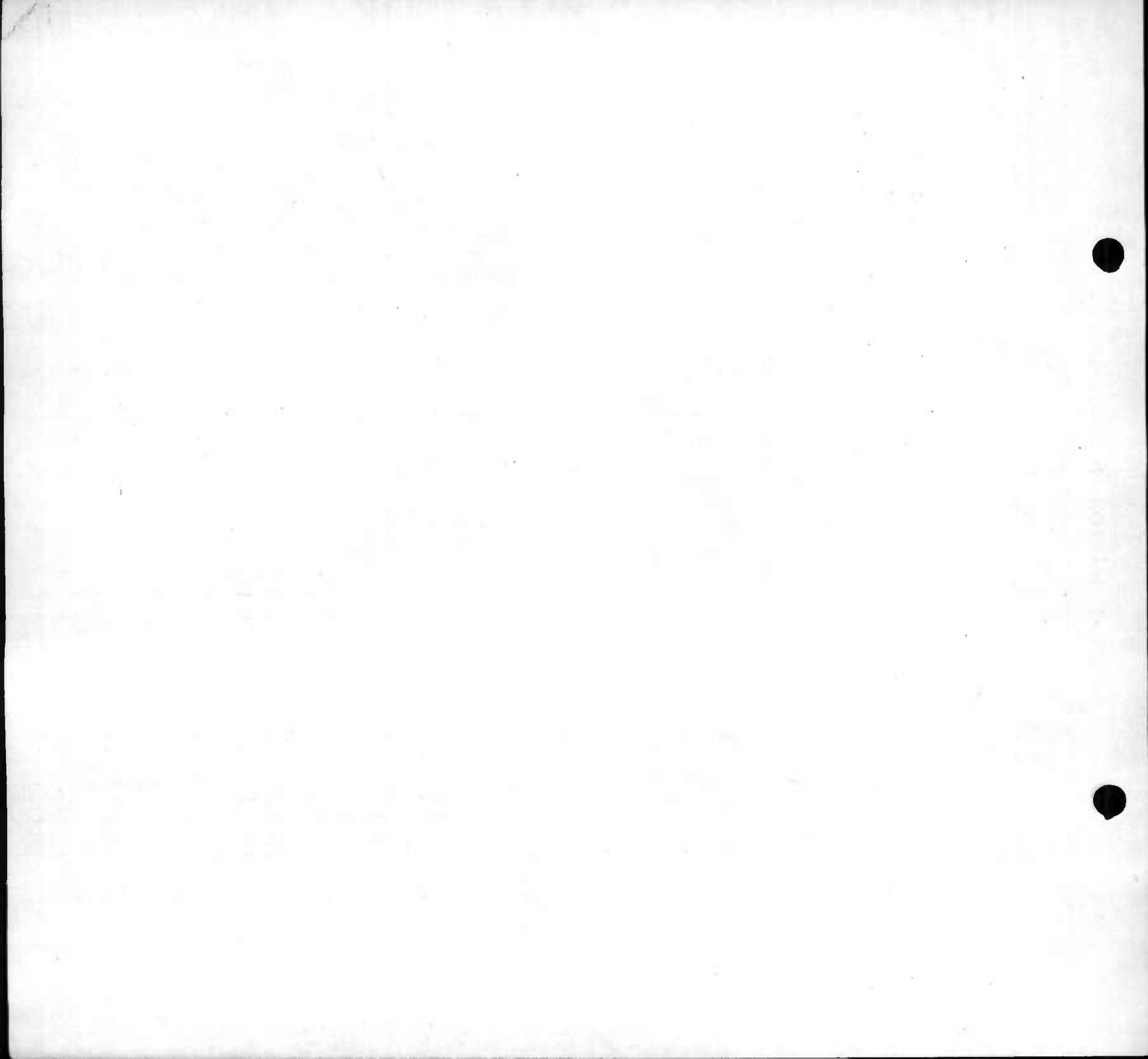
BIRTH NO. 66 00772		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00772	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Robert Cummings			2. DATE AND HOUR OF DEATH January 23, 1966 3:00 A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 16-07		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 2825 Winchester Street 21216		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Feb. 1, 1900	9. AGE (In years last birthday) 65	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Charles W. Cummings			14. MOTHER'S MAIDEN NAME Jane Berry		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-28-8413	17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue 21224		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) III ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) CARDIAC Arrhythmia DUE TO Anoxia (B) Pneumonia DUE TO (C) Cerebral Vascular Accident		INTERVAL BETWEEN ONSET AND DEATH moment or less 10 days 1 month
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from DEC. 22 1966 to JAN 23 1966 , that (I) (we) last saw the deceased alive on JAN 23 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Leonard Quadracci			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/23/66
23C. PHYSICIAN'S NAME (Type) Dr. Leonard Quadracci			23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224		
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) Burial 1/27/66		24C. NAME of CEMETERY or CREMATORY Old Field Cem.		24D. LOCATION (City, town, or county) (State) Cambridge, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR Dr. Leonard Quadracci		25C. FUNERAL DIRECTOR ADDRESS 1348 N. Calhoun St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

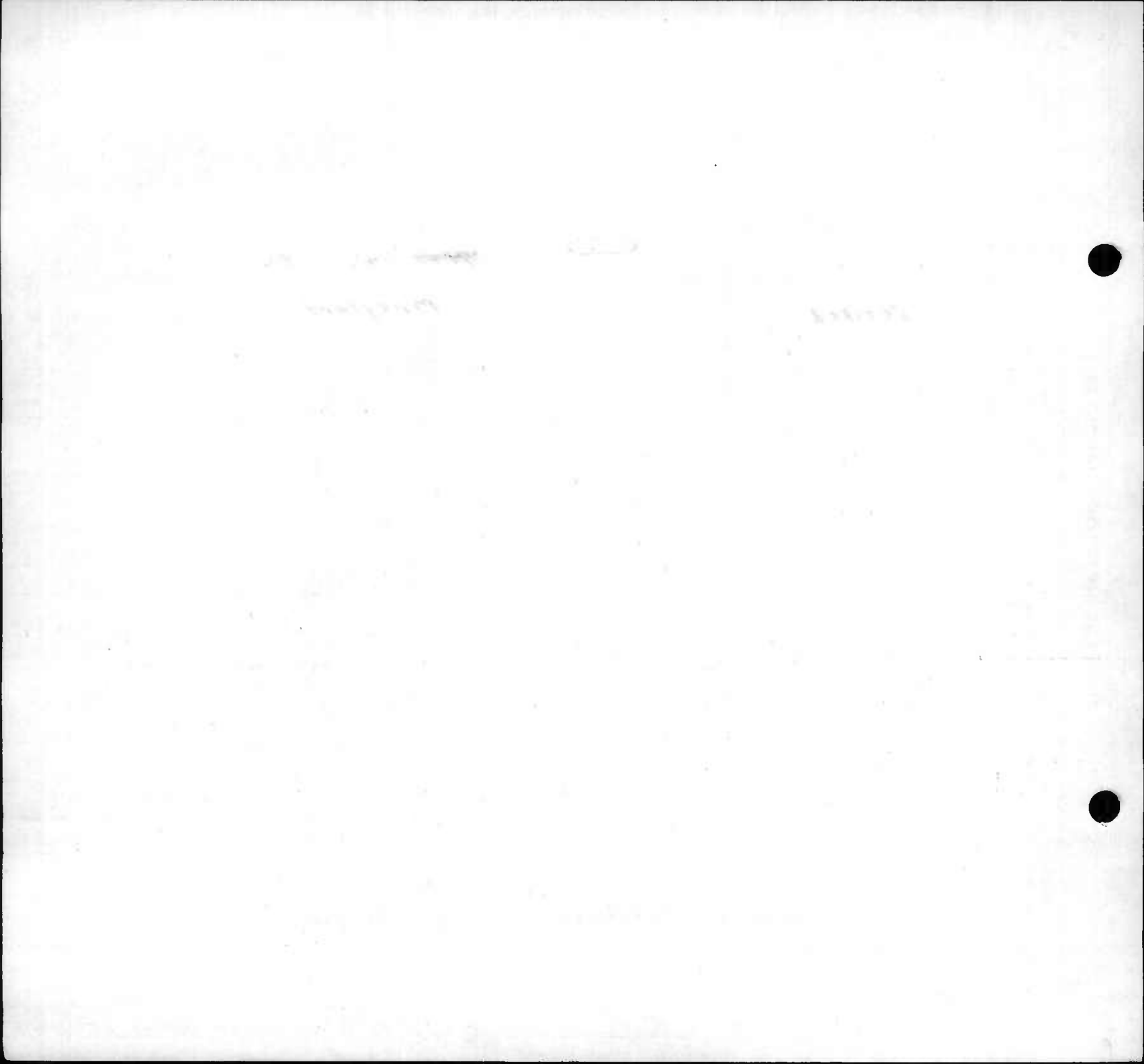
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 66 00773				
BIRTH NO. 66 00773					2. DATE AND HOUR OF DEATH 1/21/66 7:40 A.M.				
M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) Gladys Davis				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore, Md. C. CITY OR TOWN Baltimore, Md. D. STREET ADDRESS (If rural, give location) 1734 - N. Payson St.				
5. SEX Fe		6. RACE Negro		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 5/15/02		9. AGE (In years lost birthday) 63	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (State or foreign country) Maryland					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Will Thomas					14. MOTHER'S MAIDEN NAME Janie				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Lumie Davis 1734 Payson St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 270X I Hypoglycemia cause Unknown					INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Congestive Heart Failure									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>January 10</u> , 19 <u>66</u> to <u>January 21</u> , 19 <u>66</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>January 21</u> , 19 <u>66</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> <u>(did not)</u> view the body after death.									
23A. SIGNATURE Robert C. Blackmon M.D.					23B. DATE SIGNED 1/21/66				
23C. PHYSICIAN'S NAME (Type) Robert C. Blackmon M.D.					23D. ADDRESS Lutheran Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-25-66		24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem Pk.		24D. LOCATION (City, town, or county) (State) Arbutus, Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR R. E. J. Fagan			25C. FUNERAL DIRECTOR George A. Miller		ADDRESS 1548 N. Calhoun St.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

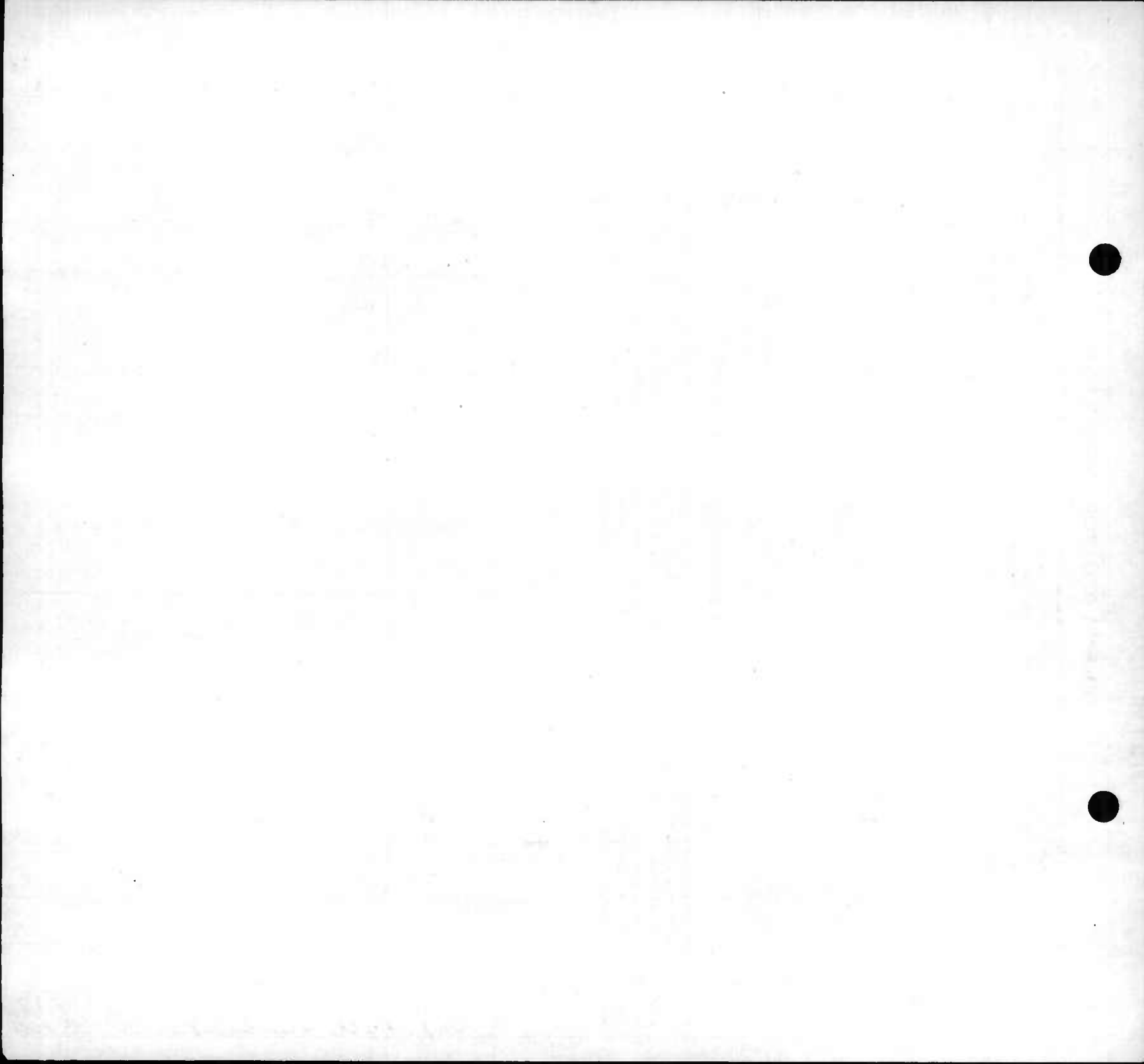
66 00774		BALTIMORE CITY HEALTH DEPARTMENT		Certificate of Death		Registered No. 66 00774	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				EVELYN HALL (Alexia)		1. 22. 66 2. 10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hosp.				A. STATE Maryland			
				B. COUNTY 20-07			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 203 N. Denison St.			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, <u>DIVORCED</u> (specify)		8. DATE OF BIRTH Oct. 31, 1900	9. AGE (In years last birthday) 65	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME Maggie R. Johnson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT John E. Hall JR. 2405 15th St N.E. D.C.			
18. 4-20-1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO myocardial infarction		(B) DUE TO Hypertension	
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1. 21 1966 to 1. 22 1966, that (I) (we) last saw the deceased alive on 1. 22 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE F. Abbousy				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1. 22. 66	
23C. PHYSICIAN'S NAME (Type) Fadhil Abbousy				23D. ADDRESS Lutheran Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-25-66		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR Robert [unclear]		25C. FUNERAL DIRECTOR [unclear] 348 N. Calhoun St			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

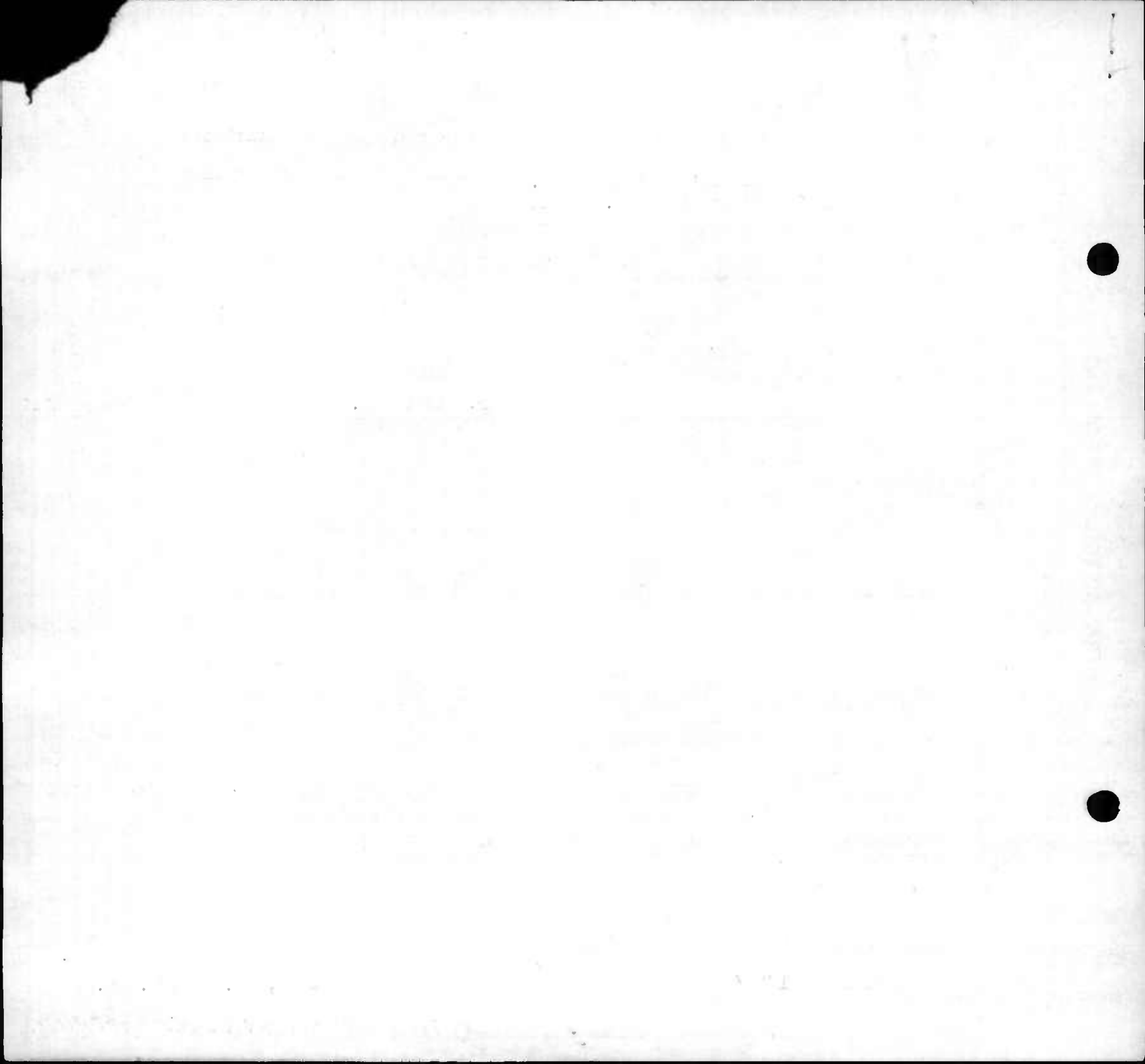
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00775	
BIRTH NO. 66 00775		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Florence A. Easton			
2. DATE AND HOUR OF DEATH January 20, 1966 9:00 A.M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1335 West 42nd Street Baltimore, Maryland 21211			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 13-08		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
D. STREET ADDRESS (If rural, give location) 1335 West 42nd Street 21211		5. SEX Female 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed			
8. DATE OF BIRTH Sept. 22, 1879 9. AGE (In years last birthday) 86		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10B. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME George Conner		14. MOTHER'S MAIDEN NAME Nannie Burke			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Mrs. Frank Stuiber same address as above	
18. 4-20-1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Myocardial Infarction (B) Coronary Arteriosclerotic Heart Disease (C)		INTERVAL BETWEEN ONSET AND DEATH Immediate 10 yrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 19 1966 to January 20 1966 that (I) (we) last saw the deceased alive on January 19 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. Allan Lier		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/21/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/24/1966		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery	
24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR 25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

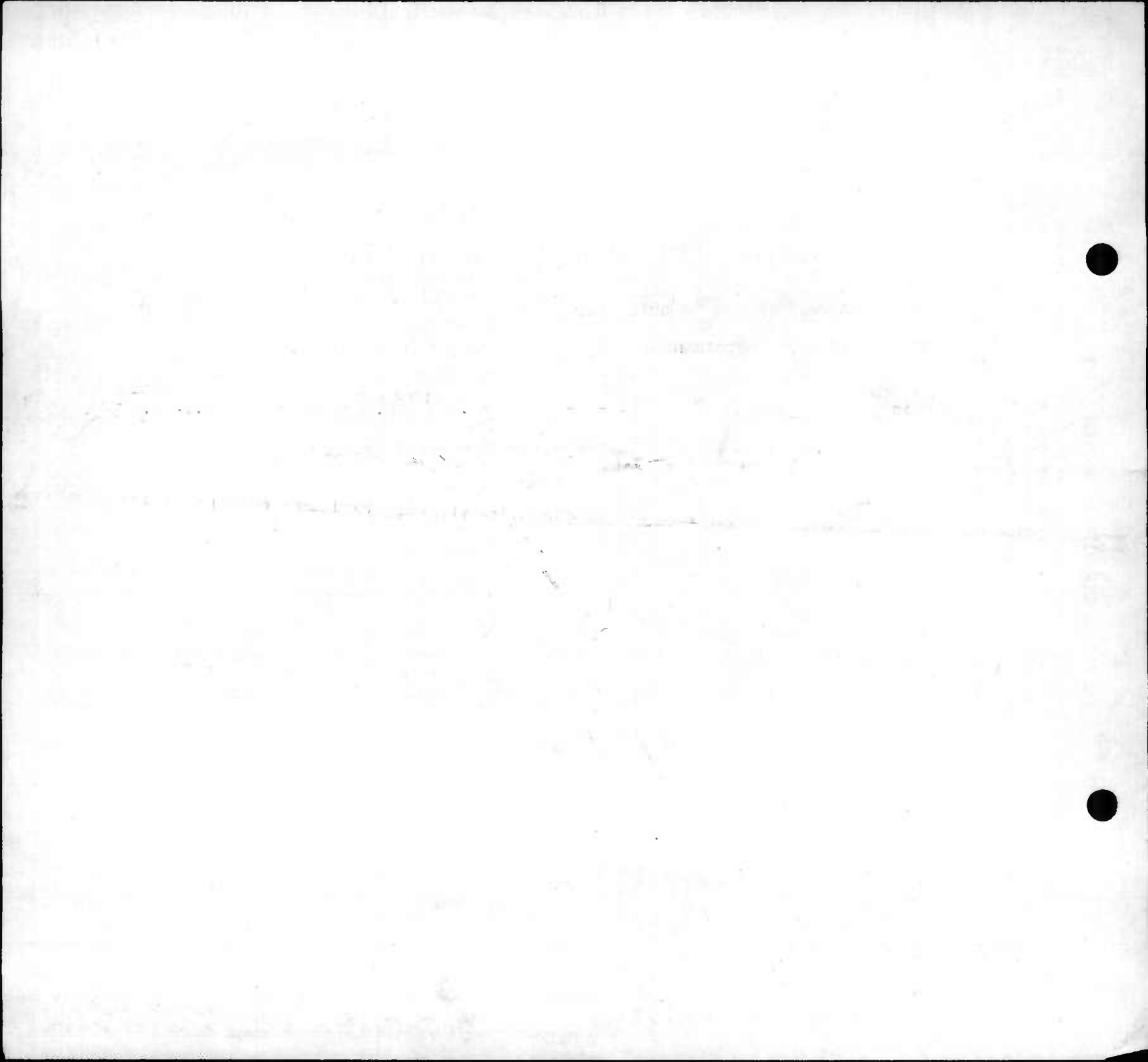
BIRTH NO. 66 00776		BALTIMORE CITY HEALTH DEPARTMENT REGISTERED NO. 66 00776	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) DOROTHY D. MULLINIX	
2. DATE AND HOUR OF DEATH 1/21/66 6:50 PM		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Children's Hospital Inc. 3825 Greenspring Ave. 21211		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Catonsville D. STREET ADDRESS (If rural, give location) 1204 TUGWELL DRIVE 21228	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 8/14/04
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY —	9. AGE (In years last birthday) 61
11. BIRTHPLACE (State or foreign country) Maryland - (Baltimore)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Not known George J. Collison		14. MOTHER'S MAIDEN NAME Not known Frances Jones	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Dr. Richard C. Lang		ADDRESS 6904 Petworth Road 21212	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 170X I METASTATIC BREAST CARCINOMA		INTERVAL BETWEEN ONSET AND DEATH 6 YRS.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —	
21C. WHERE DID INJURY OCCUR? —		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? —			
22. I certify that (I) (this hospital) attended the deceased from 12/28 1965 to 1/21 1966 , that (I) (we) lost saw the deceased alive on 1/21 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Douglas K. Sanderson		23B. DATE SIGNED 1/21/66	
23C. PHYSICIAN'S NAME (Type) DOUGLAS K. SANDERSON		23D. ADDRESS CHILDREN'S HOSPITAL - GREENSPRING AVE.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/24/66	
24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn, Md. Balto. Co.	
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Wm J. Tackman		ADDRESS 7700 Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

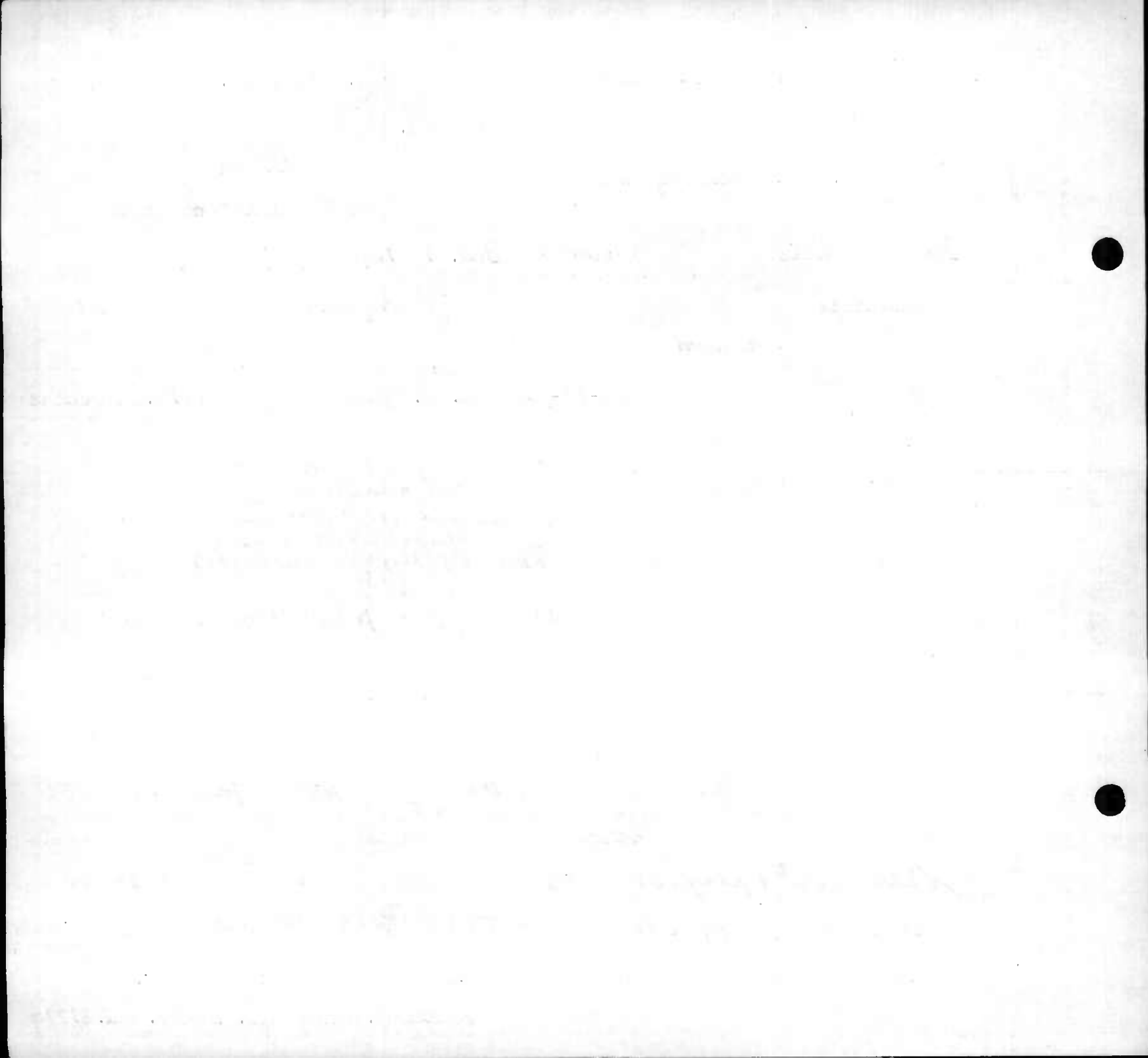
BALTIMORE CITY HEALTH DEPARTMENT						Certificate of Death		Registered No. 66 00777	
BIRTH NO. M.E. CASE NO.		66 00777							
1. NAME OF DECEASED (Type or Print)				John J. Bresnan		2. DATE AND HOUR OF DEATH 1/22/66 16 46 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY			
Maryland General Hospital				Md.		25-31			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Male		Caucasian		Widowed		4/19/95		70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Foreman		Natl. Contractor Co.		Maryland		U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Timothy Bresnan				Catherine Flannigan					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
Yes World War I		213-28-1802		Mr. John D. Bresnan		8905 Carlisle Ave Balto., Md. 1361			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) Arteriosclerotic Cardiovascular Disease				Years	
ANTECEDENT CAUSES				(B) Acute Myocardial Infarction				Hours	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
2				Yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (1) (this hospital) attended the deceased from 1/21 19 66 to 1/22 19 66, that (1) (we) lost saw the deceased alive on 1/22 19 66 and that in my (aur) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
Robert E. Stoner, M.D.				1/22/66					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
				Md. Maryland General Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		1/25/1966		New Cathedral Cemetery		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JAN 24 1966		Wm. J. Fickner & Sons		Baltimore, Md. 117					



FUNERAL DIRECTOR: IMPORTANT

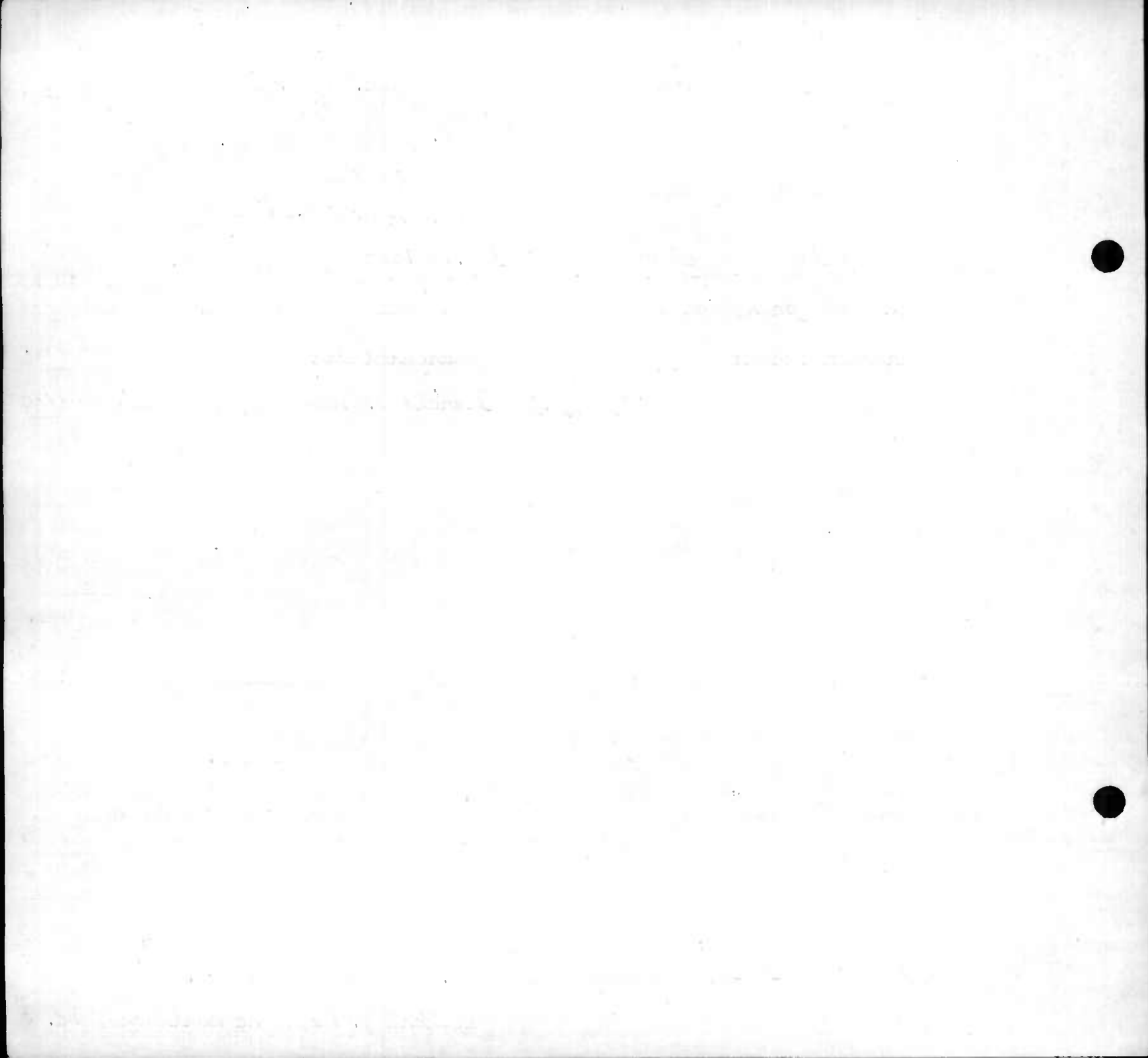
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 00778 CERTIFICATE OF DEATH					Registered No. 66 00778				
BIRTH NO. 66 00778					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <i>Helen J. Shapiro</i>					2. DATE AND HOUR OF DEATH <i>Jan. 22, 1966. 1 P.M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Mt. Sinai Nursing Home</i>					A. STATE <i>Md.</i> B. COUNTY <i>15-05</i>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>				
					D. STREET ADDRESS (If rural, give location) <i>2706 Reisterstown Road</i>				
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>Feb. 1, 1893</i>	9. AGE (In years last birthday) <i>72</i>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Seamstress</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Unknown</i>			14. MOTHER'S MAIDEN NAME <i>Unknown</i>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>219-12-5489</i>		17. INFORMANT ADDRESS <i>Mr. W. George Sanford 3121 W. Belvedere</i>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osleria, etc. It means the disease, injury or complication which caused death.) <i>422.1 H 323 X</i> CAUSE OF DEATH (A) DUE TO <i>Cardio Respiratory Failure</i> <i>Constrictive Heart Failure</i> (B) DUE TO <i>Arteriosclerotic CVA ID.</i> <i>Gen. Arteriosclerosis</i> (C) <i>Chn. Hypertrophic Arteritis</i>			INTERVAL BETWEEN ONSET AND DEATH						
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Morphine ADDICTION</i>						
19A. DATE OF OPERATION <i>0</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 15</i> to <i>Jan 22</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Jan 22</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <i>(we)</i> (did not) view the body after death.									
23A. SIGNATURE <i>Willard Applefeld</i> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>1/24/66</i>		
23C. PHYSICIAN'S NAME (Type) <i>WILLARD APPLEFELD</i> M.D.					23D. ADDRESS <i>5501 Park Heights Av. Balto. MD</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/25/66</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 24 1966</i>			25B. NAME OF REGISTRAR <i>Leonard J. Ruck Inc.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Balto. Md. 21214</i>				



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00779		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00779	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Francis Tucker			2. DATE AND HOUR OF DEATH Jan. 23, 1966 2:30 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Ardleigh Nursing Home			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 27-38		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 5909 Chingapin Parkway		
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH Feb. 18, 1888	9. AGE (In years last birthday) 77	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Contractor		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Benjamin Tucker		
14. MOTHER'S MAIDEN NAME Margaret Drury			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 215037703			17. INFORMANT Francis D. Tucker ADDRESS 7904 Oakdale Ave/34		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) EMPHYSEMA			INTERVAL BETWEEN ONSET AND DEATH 5 YRS.		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE			10 YRS.		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 18, 1966 to Jan 23, 1966 , that (I) (we) last saw the deceased alive on Jan 21, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lloyd E. Saylor M.D.				23B. DATE SIGNED Jan 24, 1966	
23C. PHYSICIAN'S NAME (Type) LLOYD E. SAYLOR				23D. ADDRESS 3962 Greenmount Ave Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 1-26-66		24C. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR Leonard J. Ruck		25C. FUNERAL DIRECTOR ADDRESS Ruck Inc Baltimore, Md.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED

(Type or Print)

Leonard Leo Endrusick

2. DATE AND HOUR PRONOUNCED DEAD

1/22/66 4:50 p.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE *Maryland*B. COUNTY *Howard*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore - rural

D. STREET ADDRESS (If rural, give location)

Rte. 218 Jessup, Md.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

June 18, 1927

9. AGE (In years last birthday)

38

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Employee B and O Railroad Co.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Penna.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John Endrusick

14. MOTHER'S MAIDEN NAME

Agnes Sieczkowski

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

yes

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

George Endrusick Wyoming, Penna.

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

Cranio-cerebral injury

(A) DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

U.S. Rte. 1 near Rte. 477

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

1 22 66 3:05 p.m.

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

driver in auto-auto collision

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐*1/23/66*

23A. BURIAL CREMATION, REMOVAL (Specify)

burial

23B. DATE

1-27-66

23C. NAME OF CEMETERY or CREMATORY

St. Joseph's Cemetery

23D. LOCATION

(City, town, or county)

(State)

West Wyoming, Luzerne Penna.

24A. DATE REC'D BY HEALTH DEPT.

JAN 24 1966

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

Leonard J. Ruck Inc Baltimore, Md.



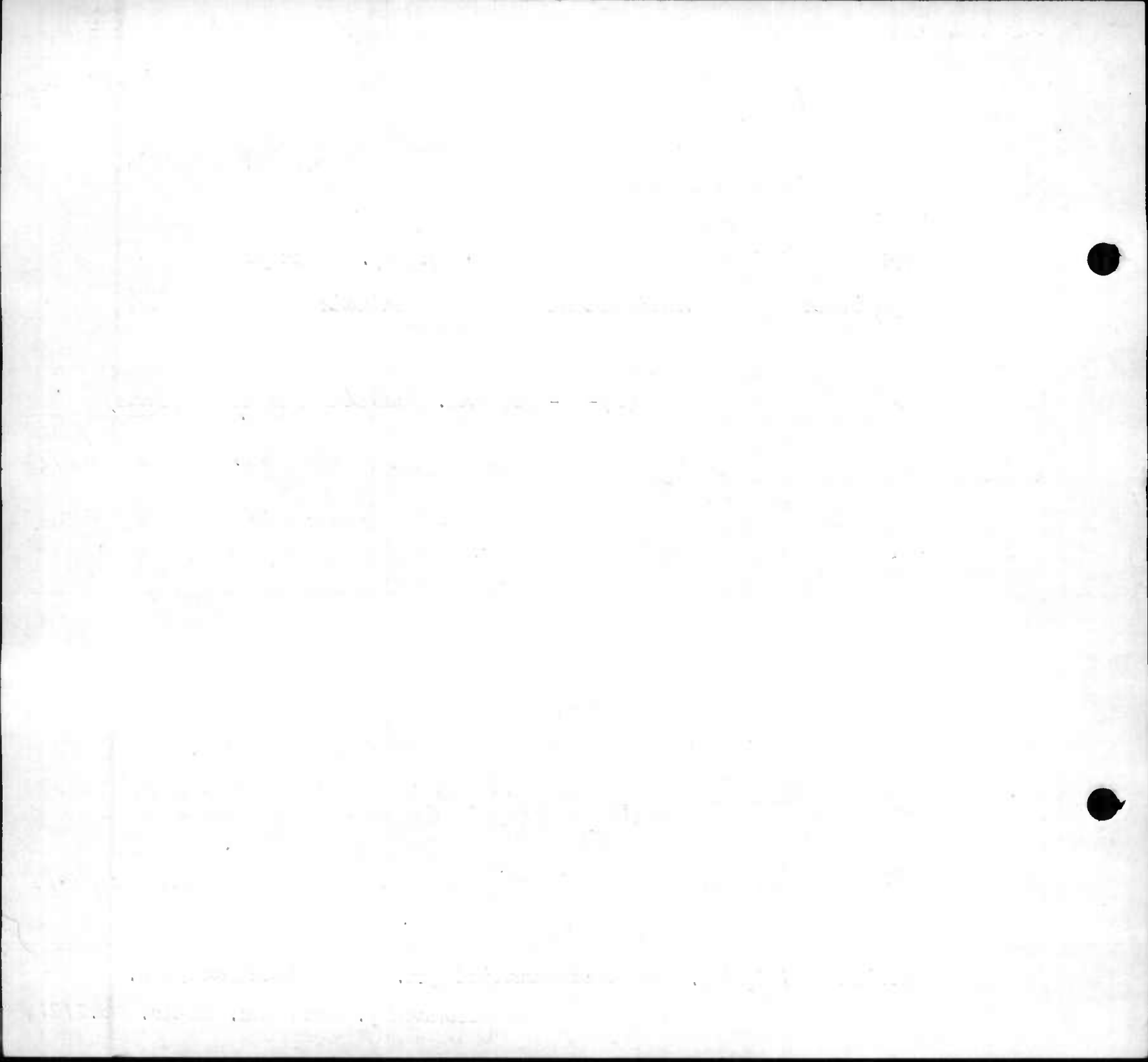
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1957-58
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 66 00781				
BIRTH NO. 66 00781									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) ANDREW S. THOMAS					2. DATE AND HOUR OF DEATH JAN. 21, 1966 8:15 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY TALBOTT				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL					C. CITY OR TOWN (If outside city limits, write RURAL and give township) ROUTE 2 BOX 27A EASTON 10-00				
D. STREET ADDRESS (If rural, give location)									
5. SEX MALE	6. RACE White	7. MARRIED, NEVER MARRIED MARRIED		8. DATE OF BIRTH 2-3-24 09.	9. AGE (In years last birthday) 56	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10B. KIND OF BUSINESS OR INDUSTRY Architectural		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME PHILIP THOMAS				14. MOTHER'S MAIDEN NAME DELLA HAISLIP					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 489-03-9384		17. INFORMANT Mrs. Isabella Thomas			
				ADDRESS (Same)					
18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ASPIRATION PNEUMONIA				CAUSE OF DEATH (A) DUE TO ASPIRATION PNEUMONIA			INTERVAL BETWEEN ONSET AND DEATH 2 DAYS		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. HYPERTENSIVE ENCEPHALOPATHY				(B) DUE TO HYPERTENSIVE ENCEPHALOPATHY			2 WEEKS		
				(C) H C V D			? YEARS		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (<u>this hospital</u>) attended the deceased from DEC. 18 19 65 to JAN. 21 19 66 , that (I) (we) last saw the deceased alive on JAN. 21 19 66 and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (<u>did</u>) (did not) view the body after death.									
23A. SIGNATURE Barry Wayne Uher					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Jan. 21, 1966		
23C. PHYSICIAN'S NAME (Type) BARRY WAYNE UHER					23D. ADDRESS JOHNS HOPKINS HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/25/66		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR John			25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214				
		25D. ADDRESS							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00782		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 00782	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) William F. Wetters			2. DATE AND HOUR OF DEATH Jan. 22, 1966. 6:00 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3911 Woodlea Avenue			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 27-01		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 3911 Woodlea Avenue		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Dec. 24, 1900	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Composer		10B. KIND OF BUSINESS OR INDUSTRY Sunpapers		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME George Wetters			14. MOTHER'S MAIDEN NAME Margaret Crammer		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 313-03-2778		17. INFORMANT Mrs. Hilda Wetters	
				ADDRESS (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 162.1 I Carcinomatosis (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH (A) DUE TO Bronchogenic Carcinoma of lung.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO 1 yr.		
			(C) 1 yr.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Myocardial Infarction		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		19A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/16/66 to January 19 66 , that (I) (we) last saw the deceased alive on 1/16/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Albert B. Bradley			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/22/66
23C. PHYSICIAN'S NAME (Type) Albert B. Bradley			23D. ADDRESS 4900 Belair Road		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/25/66		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214	

Constitution
Baptist Church 17

Wm. B. Smith
17

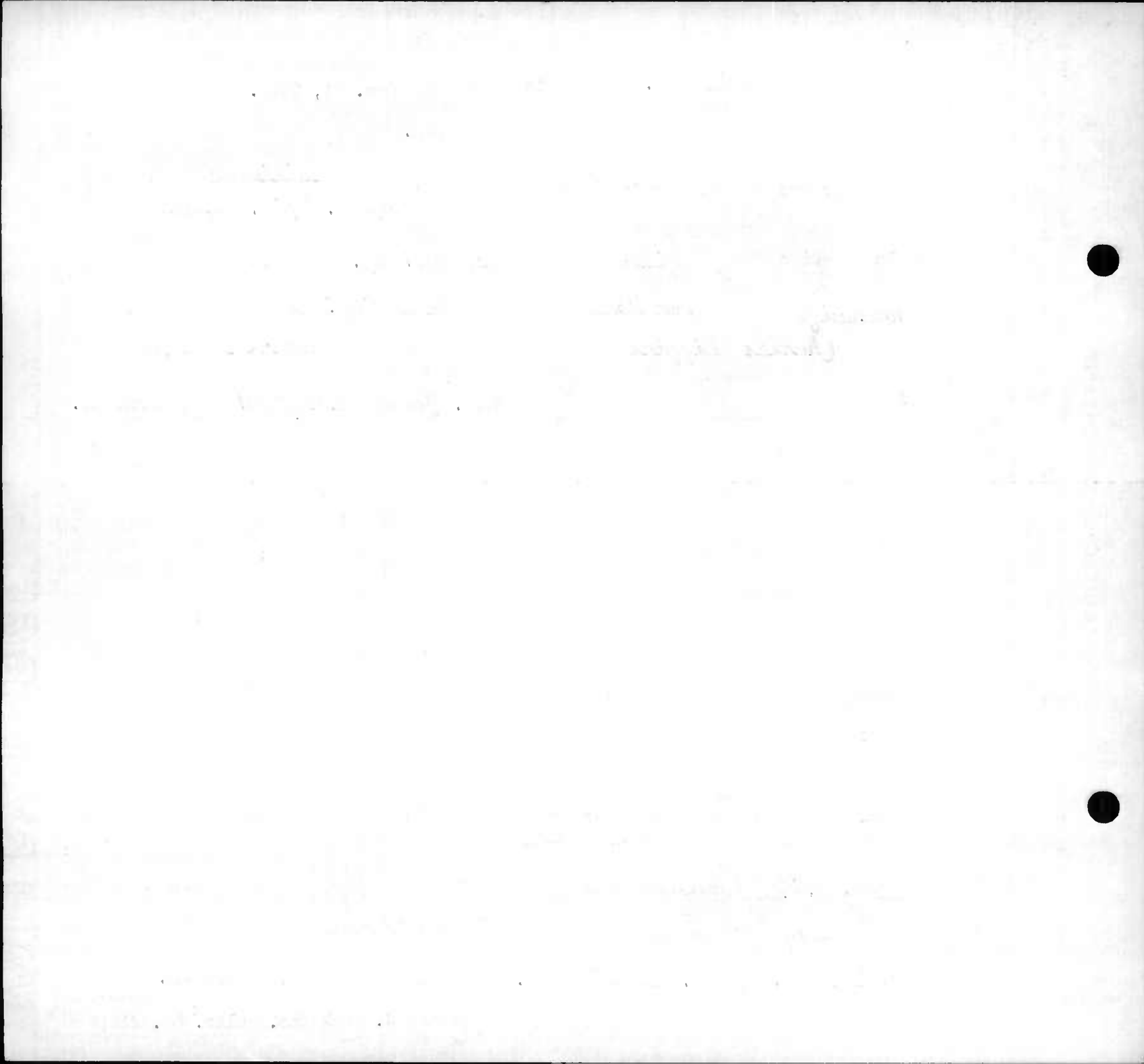
Wm. B. Smith
17

Wm. B. Smith

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

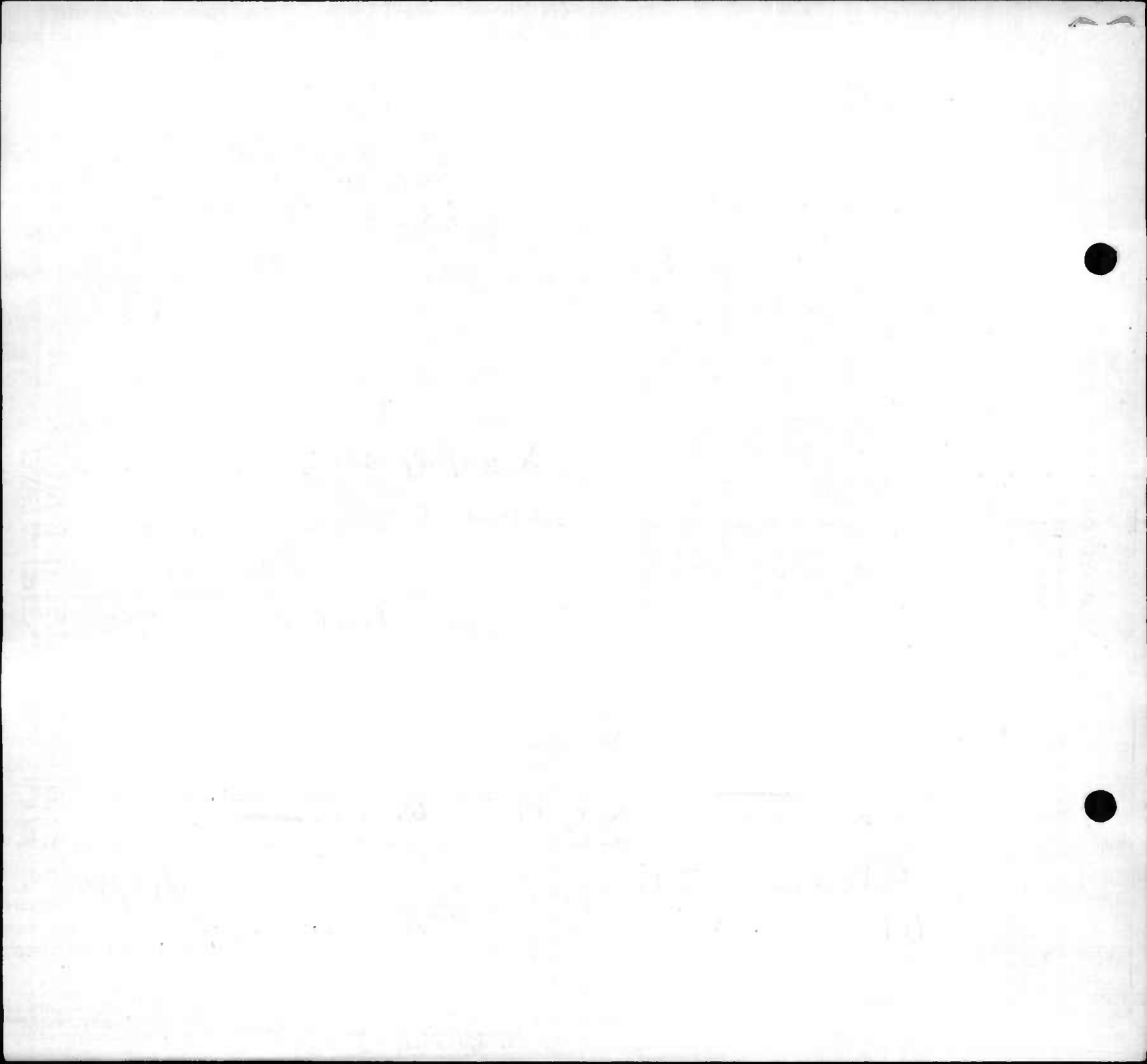
66 00783		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00783	
CERTIFICATE OF DEATH					
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		JESSIE A. Metz		Jan. 21, 1966. 6:20 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Harford Gardens Nursing Home		Md. 9-04			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
Female		White		Widow	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Housewife		Own Home		May 20, 1885.	
13. FATHER'S NAME		11. BIRTHPLACE (State or foreign country)		9. AGE (In years last birthday)	
Charles Biggins		West Virginia		80	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY?	
No				USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Charles Biggins		Rachel Feathers			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.			
No					
17. INFORMANT		ADDRESS			
Mrs. James DePuey		2301 Pentland Dr. #34			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		1 month	
ANTECEDENT CAUSES		(B) DUE TO		Several Years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from May 19 64 to January 19 66, that (I) (we) last saw the deceased alive on January 20 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Loy M. Zimmerman				Jan. 22, 1966	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Loy M. Zimmerman		3202 Harford Rd Baltimore, Md			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		1/25/66		Lorraine Pk. Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 24 1966		Leonard J. Ruck Inc. Balto. Md. 21214		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 66 00784	
BIRTH NO. 66 00784		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ANNA P. Waddell		2. DATE AND HOUR OF DEATH 1-18-1966 10 A	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 633 E. 33rd St				A. STATE MD B. COUNTY 9-05			
5. SEX F 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow				8. DATE OF BIRTH July 22, 1890		9. AGE (In years last birthday) 75	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) N.C.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Felix Howell			
14. MOTHER'S MAIDEN NAME Rachel Adams				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. None				17. INFORMANT Lona Waddell ADDRESS Same			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 451XX+260X				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) Assectured aneurysm		1 minute	
ANTECEDENT CAUSES				(B) arteriosclerosis		4 years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Diabetes Mellitus		4 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 1961 to Dec. 14 1965 , that (I) (we) last saw the deceased alive on Dec 14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE William F. Fritz				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/19/66	
23C. PHYSICIAN'S NAME (Type) William F. Fritz				23D. ADDRESS 2 West University Parkway Baltimore 21218, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-21-60		24C. NAME OF CEMETERY or CREMATORY MT. Zion Church		24D. LOCATION (City, town, or county) (State) BELAIR-HARFORD Co. MD	
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR Chas. F. Evans & Son		25C. FUNERAL DIRECTOR Chas. F. Evans & Son		ADDRESS 8802 HARFORD Rd	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 66 00785				
BIRTH NO. 66 00785					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) WALLIS, MARION F.					2. DATE AND HOUR OF DEATH 1/19/66 10:45 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 12-02				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				
					D. STREET ADDRESS (If rural, give location) 3305 GUILFORD AVE				
5. SEX ♀	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 7/13/07	9. AGE (in years last birthday) 58	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECY		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? US
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECY					10B. KIND OF BUSINESS OR INDUSTRY LAW		13. FATHER'S NAME HUGH WRIGHT WALLIS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT (BROTHER) HUGH W. WALLIS		
18. 431X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) - Dissecting aneurysm, ascending aorta					CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) DUE TO		(B) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					(C) DUE TO				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 1/17/66 19 to 1/19 1966, that (I) (we) lost saw the deceased alive on 1/19 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE Charles S. Brown					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 1/19/66	
23C. PHYSICIAN'S NAME (Type) CHARLES S. BROWN					23D. ADDRESS M.D. UNION MEMORIAL HOSP				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JAN. 22		24C. NAME OF CEMETERY or CREMATORY CHESTER		24D. LOCATION (City, town, or county) (State) CHESTERTOWN MD.			
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR Edgar L. Lane			25C. FUNERAL DIRECTOR ADDRESS Church Hill, Md.				

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Handwritten text, possibly a signature or date, located in the lower left quadrant.

Handwritten text, possibly a signature or date, located at the bottom center.

66 00786

BALTIMORE CITY HEALTH DEPARTMENT

66 00786

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

FRANCIS X. UNKELBACH

2. DATE AND HOUR PRONOUNCED DEAD

January 21, 1966 12:05 P

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Me5cy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

XXXXXXX Rural - Dundalk

D. STREET ADDRESS (If rural, give location)

835 Mildred Avenue 21222

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

OCTOBER
November 22, 19239. AGE (In years
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Cable Installer

10B. KIND OF BUSINESS OR INDUSTRY

Gas + Electric Co.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Alphonsus Unkelbach

14. MOTHER'S MAIDEN NAME

Sadie Fasano

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W.W. 11

16. SOCIAL
SECURITY NO.

215-18-1888

17. INFORMANT

ADDRESS

Theresa F. Unkelbach 835 Mildred Ave. #22

18. 420.01

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
1/21/6623A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1-25-66

23C. NAME of CEMETERY or CREMATORY

New Cathedral Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JAN 24 1966

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

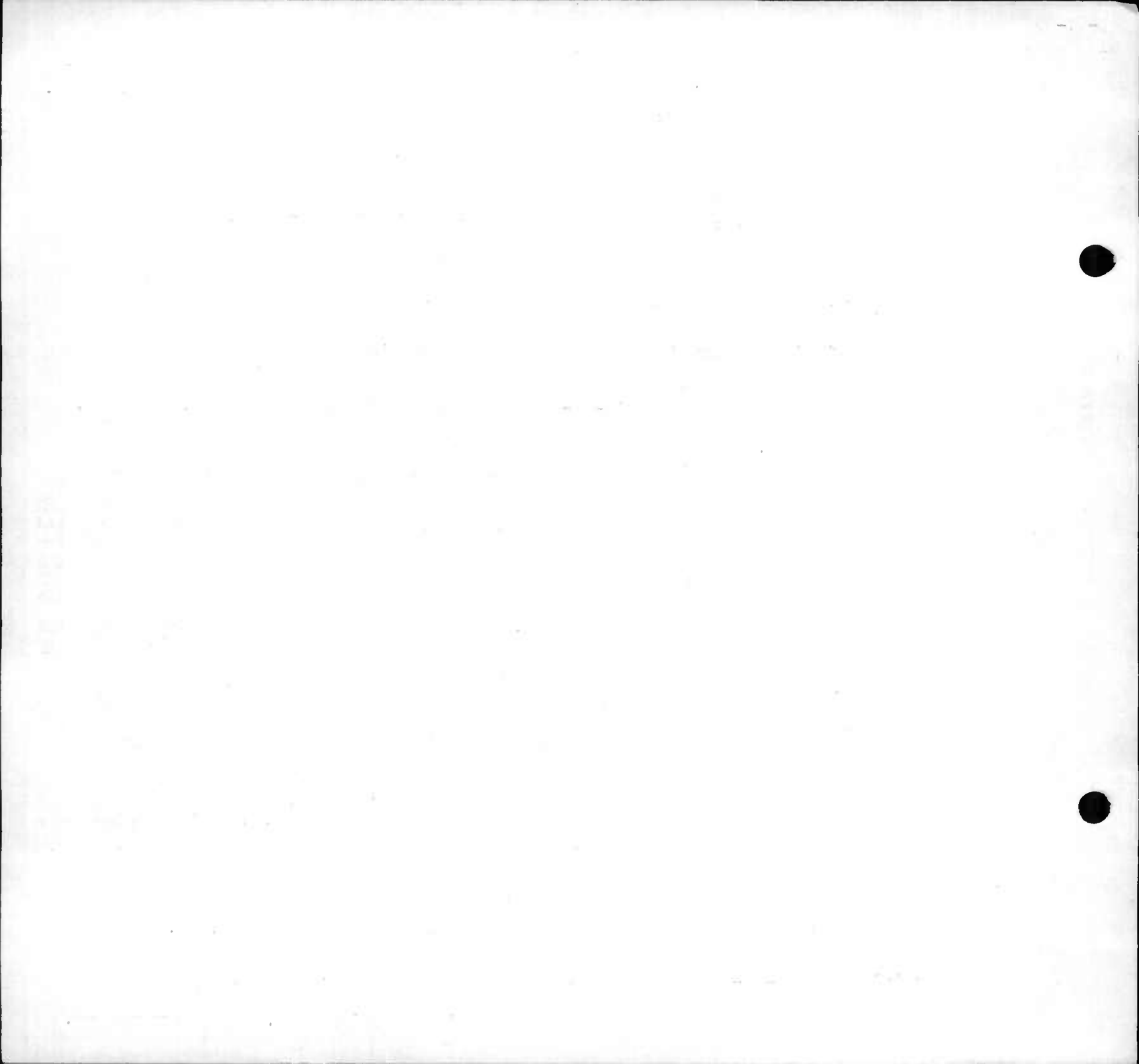
ADDRESS

Charles S. Zeiler 901 S. Conkling St. #24

WALLACE FORGE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

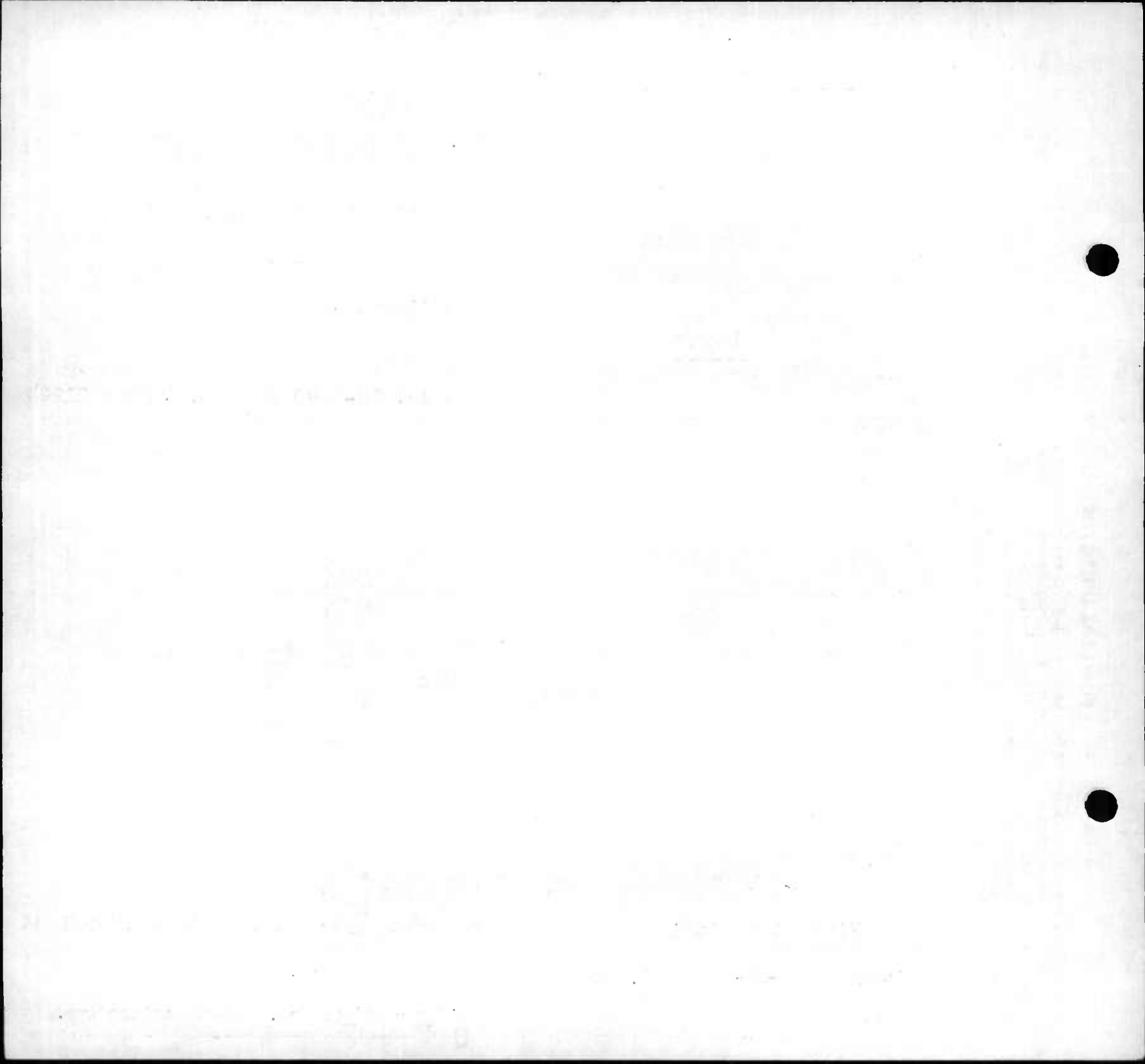
BIRTH NO. T-563		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00787	
M.E. CASE NO.		66 00787		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) THAMERT, Katherine			2. DATE AND HOUR OF DEATH 1/23/66 2:30 A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 3-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 406 Bond Street - 21231		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 3/18/86	9. AGE (In years last birthday) 79	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME William Gegner		
14. MOTHER'S MAIDEN NAME Lena Zimmerman			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 219-05-5114			17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Ave., Balto, Md. 21224		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 433, 1 Antricular Fibrillation (A) DUE TO Generalized Arteriosclerosis (B) DUE TO (C) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 20 minutes many years		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II Basilar artery insuff.			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-13 19 66 to 1-23 19 66 , that (I) (we) lost saw the deceased alive on 1-13 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE John R. Burton M.D.				23B. DATE SIGNED 1-23-66	
23C. PHYSICIAN'S NAME (Type) JOHN R. BURTON				23D. ADDRESS M.D. 4940 Eastern Avenue, Balto., Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-26-1966		24C. NAME OF CEMETERY or CREMATORY Oak Lawn	
24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966			
25B. NAME OF REGISTRAR 00012, Baltimore		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901 Eastern Ave.			



FUNERAL DIRECTOR: IMPORTANT

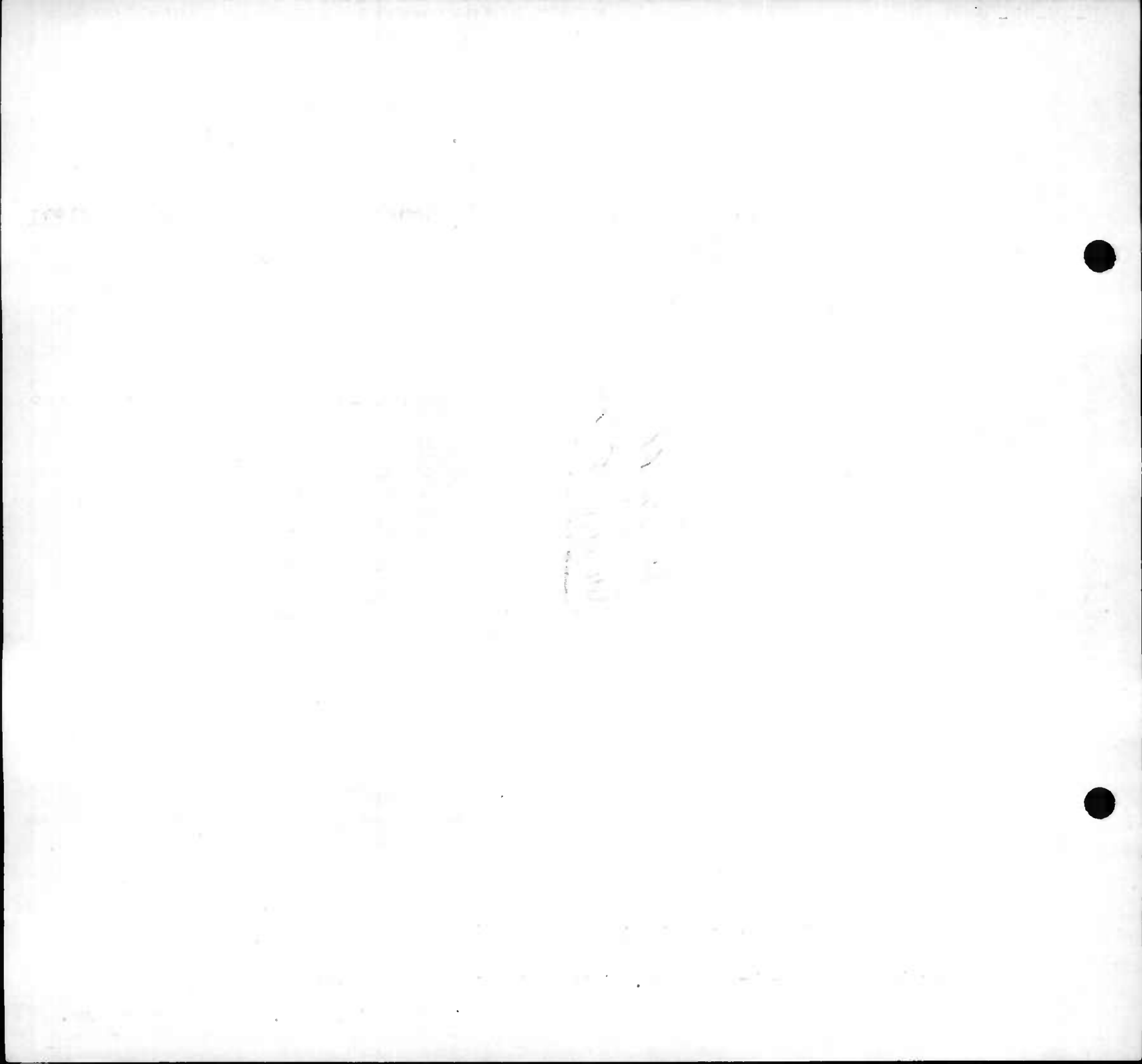
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00788	
BIRTH NO. 66 00788		CERTIFICATE OF DEATH		Registered No. 66 00788	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Meyer Robert F. MEYER		2. DATE AND HOUR OF DEATH 1-20-66 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. M.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Md. 525 N. Milton Ave		B. COUNTY	
Baltimore City Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore 007 md	
4940 Eastern Ave		D. STREET ADDRESS (If rural, give location)		525 North Milton Avenue 21205	
5. SEX M	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 12-20-96	9. AGE (In years last birthday) 64 69	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Merchant Seaman		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Louis Meyer - Meyer		14. MOTHER'S MAIDEN NAME Spillie		12. CITIZEN OF WHAT COUNTRY? US	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224	
18. 199.2.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) metastatic adenocarcinoma (B) primary unknown (C)		INTERVAL BETWEEN ONSET AND DEATH 6 mo.	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work Not While At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov-9-65 19 to Jan 20-66 19 that (I) (we) last saw the deceased alive on Jan 19-66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Vincent Felitti		M.D. Attending Phys. Med. Director Staff Phys.		23B. DATE SIGNED 1-20-66	
23C. PHYSICIAN'S NAME (Type) Vincent Felitti		23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-24-1966		24C. NAME OF CEMETERY or CREMATORY Mt. Carmel	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901 Eastern Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

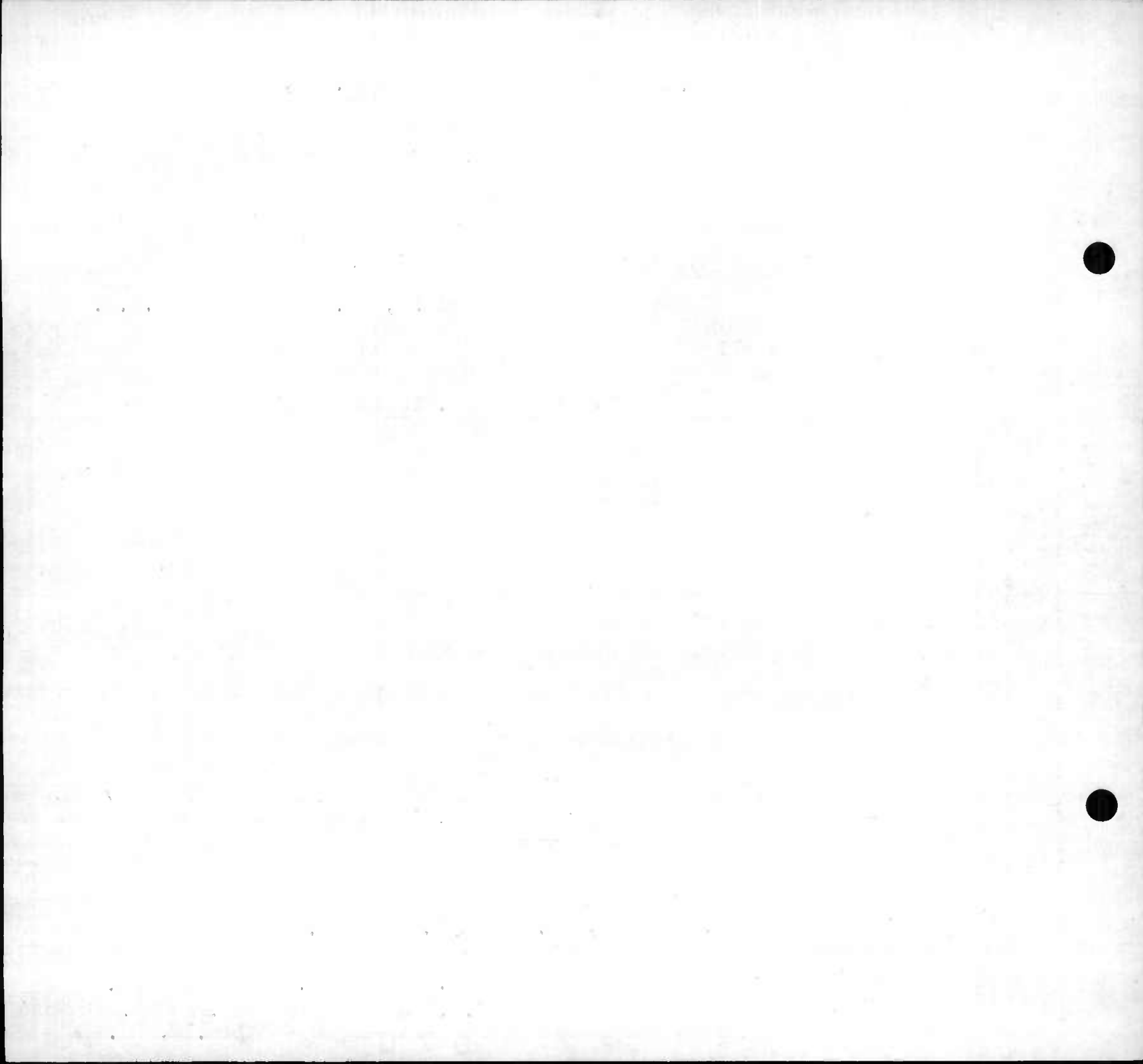
BIRTH NO. R-650 66 00789		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00789	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Perum Marie		2. DATE AND HOUR OF DEATH January 20 1966 12:45 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospital 4940 Eastern Avenue		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 233 S. Washington St C. CITY OR TOWN (If outside city limits, write RURAL and give township) 233 Baltimore md 21231 D. STREET ADDRESS (If rural, give location) 233 South Washington Street 21231			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 10-5-85	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Poland	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Chronic lymphocytic leukemia		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH Approx 4 years	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. fractured hip.		20. MEDICAL EXAMINER'S CERTIFICATION Jan 22 66 Werner		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 2 days.	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-17-65 19 to 1-20-66 19, that (I) (we) last saw the deceased alive on 1-19-66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Vincent Felitti				23B. DATE SIGNED 1-20-66	
23C. PHYSICIAN'S NAME (Type) Vincent Felitti				23D. ADDRESS 4940 Eastern Avenue, Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-24-1966		24C. NAME OF CEMETERY or CREMATORY St. Michael Ukrainian	
24D. LOCATION Baltimore County, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966			
25B. NAME OF REGISTRAR Lilly & Zeiler Inc.		25C. FUNERAL DIRECTOR ADDRESS 1901 Eastern Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

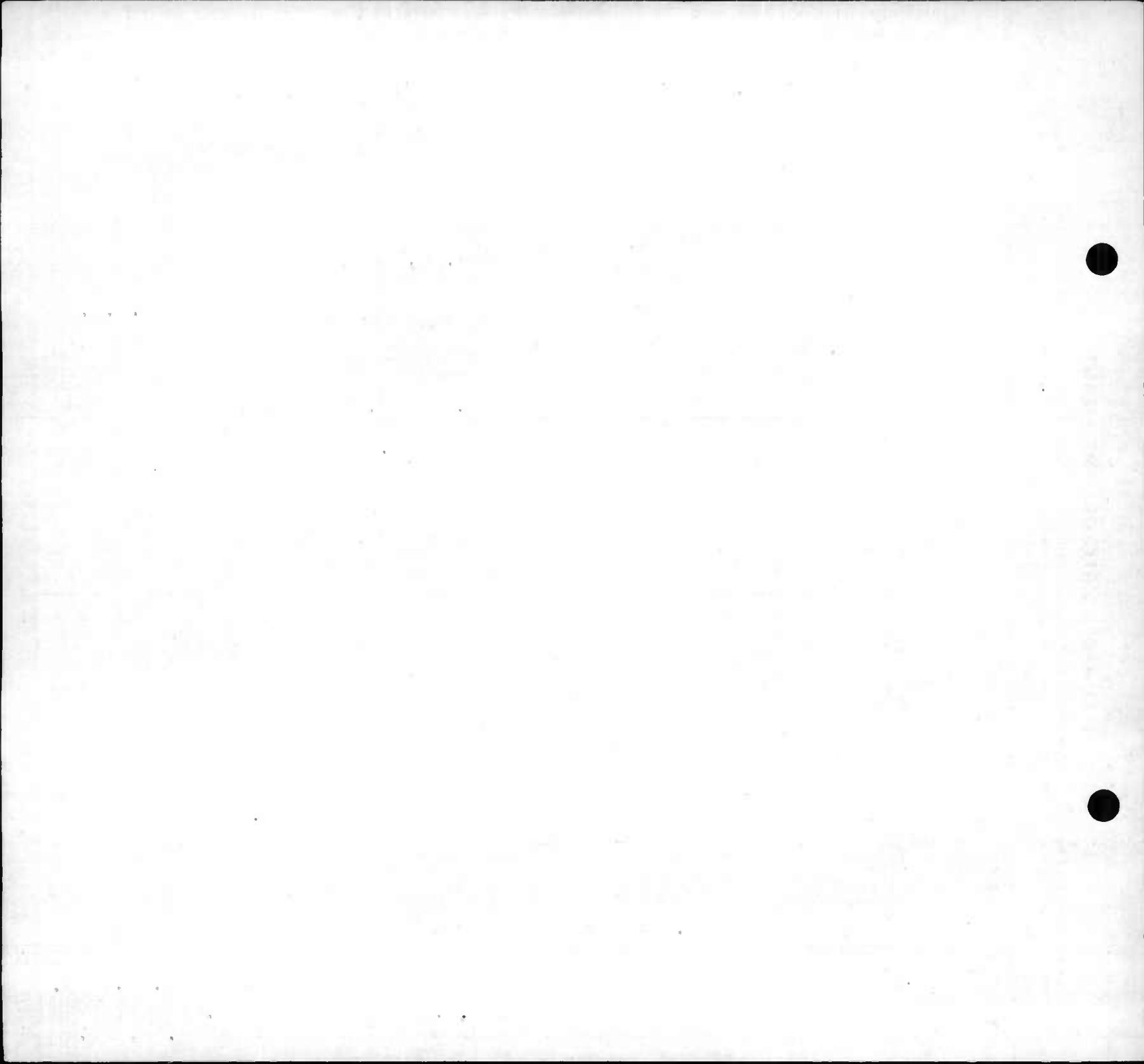
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 00790</u>	
66 00790				CERTIFICATE OF DEATH	
BIRTH NO. M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		William J. Bissell		Jan. 21, 1966 <u>8:45A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE Maryland		
3547 Newland Road			B. COUNTY 1201		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			Baltimore		
			D. STREET ADDRESS (If rural, give location)		
			3547 Newland Road		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8/18/1885	9. AGE (In years last birthday) 80	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive
		10B. KIND OF BUSINESS OR INDUSTRY Banking	11. BIRTHPLACE (State or foreign country) Belair, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Benjamin Bissell			14. MOTHER'S MAIDEN NAME Elizabeth Henshaw		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-07-6042	17. INFORMANT Mrs. Clara Bissell		ADDRESS (Same)
18. <u>420.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>A-S heart disease</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<u>Bronchitis, chronic, severe</u> <u>15 yrs.</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/20</u> <u>1955</u> to <u>Jan 21</u> <u>1966</u> . that (I) <u>last</u> saw the deceased alive on <u>1/11</u> <u>1966</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>did</u> (did not) view the body after death.					
23A. SIGNATURE <u>Norman R. Freeman, Jr.</u>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>1/21/66</u>
23C. PHYSICIAN'S NAME (Type) Norman R. Freeman, Jr., M.D.			23D. ADDRESS 11 W. 29th St.		
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE 1/24/66	24C. NAME OF CEMETERY or CREMATORY New Cathedral Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR <u>H.W. Jenkins & Sons Co.</u>		25C. FUNERAL DIRECTOR ADDRESS 4905 York Road Balto. 12, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 00791</u>	
66 00791				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		Mary I. Bacon		January 19, 1966 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 5807 Hillen Road		A. STATE Maryland			
		B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		5807 Hillen Road			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	B. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
F	W	Widowed	Dec. 30, 1885	80	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Own Home		Baltimore, Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
George W. Harper		Sarah Elizabeth Crouch		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No				Mrs. John O. Gillespie, 2122 Dulaney Valley Road	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>May 1964</u> to <u>Jan. 1966</u> , that (I) (we) last saw the deceased alive on <u>18 Jan. 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (didn't) view the body after death.					
23A. SIGNATURE <u>Wm. H. Kammer, Jr.</u>				23B. DATE SIGNED <u>21 Jan. 1966</u>	
23C. PHYSICIAN'S NAME (Type) William H. Kammer				23D. ADDRESS 6011 York Road	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1/21/1966		Moreland Memorial Park	
				Parkville, Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 24 1966		C. J. B. Jenkins		H. W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

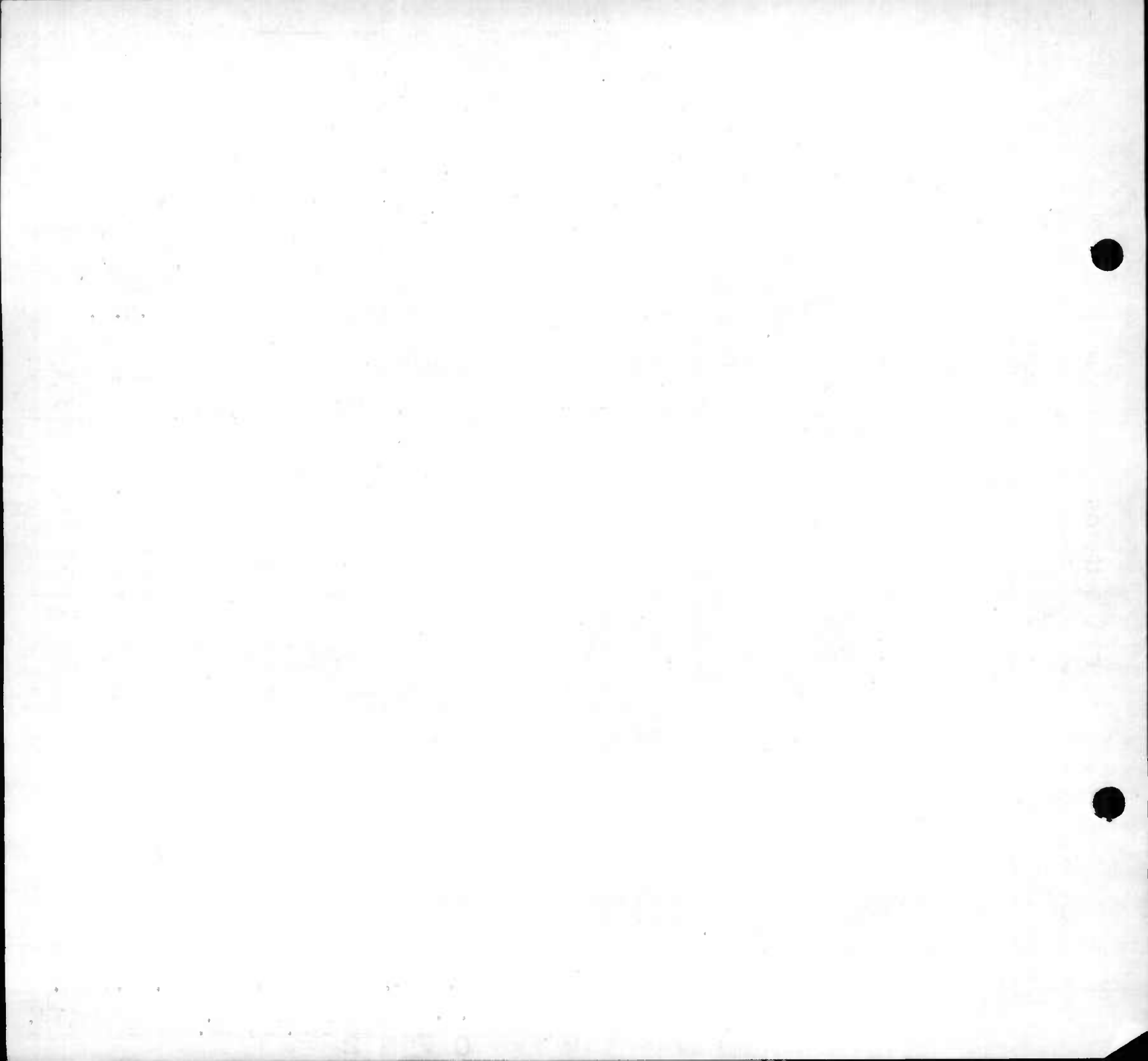
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00792	
BIRTH NO. 66 00792				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Frank M. Fossett			2. DATE AND HOUR OF DEATH 1/21/66 4:55 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Union Memorial Hospital FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 12-02		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) Blackstone Apts. #204		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH 12/28/04	9. AGE (In years last birthday) 61 yrs	10. Under 1 Yr. Months: Ooys: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman - BROKER Insurance			11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Henry Clay Fossett			14. MOTHER'S MAIDEN NAME Mary Murphy		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII			16. SOCIAL SECURITY NO.		17. INFORMANT MRS. LAWRENCE RODOWSKY
			ADDRESS 4306 NORWOOD ROAD		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 420.1 I (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH (A) Myocardial Infarction DUE TO Coronary Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 1/21/66 - 1/21/66
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Massive aspiration of DUE TO gastrointestinal contents both lower		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(C) Full lobes of lungs! N/A		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from 1/21 19 66 to 1/21 19 66 , that the (we) last saw the deceased alive on 1/21 19 66 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. the (We) (did) did not view the body after death.					
23A. SIGNATURE Harry J. Brown M.O.				23B. DATE SIGNED 1/21/66	
23C. PHYSICIAN'S NAME (Type) DR. HARRY J. BROWN M.O.				23D. ADDRESS UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/24/66		24C. NAME OF CEMETERY OR CREMATORY New Cathedral	
		24D. LOCATION Baltimore		24E. STATE Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.	
				ADDRESS 4905 York Road Balto. 12, Md.	

5/5/61

1000 1000 1000 1000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

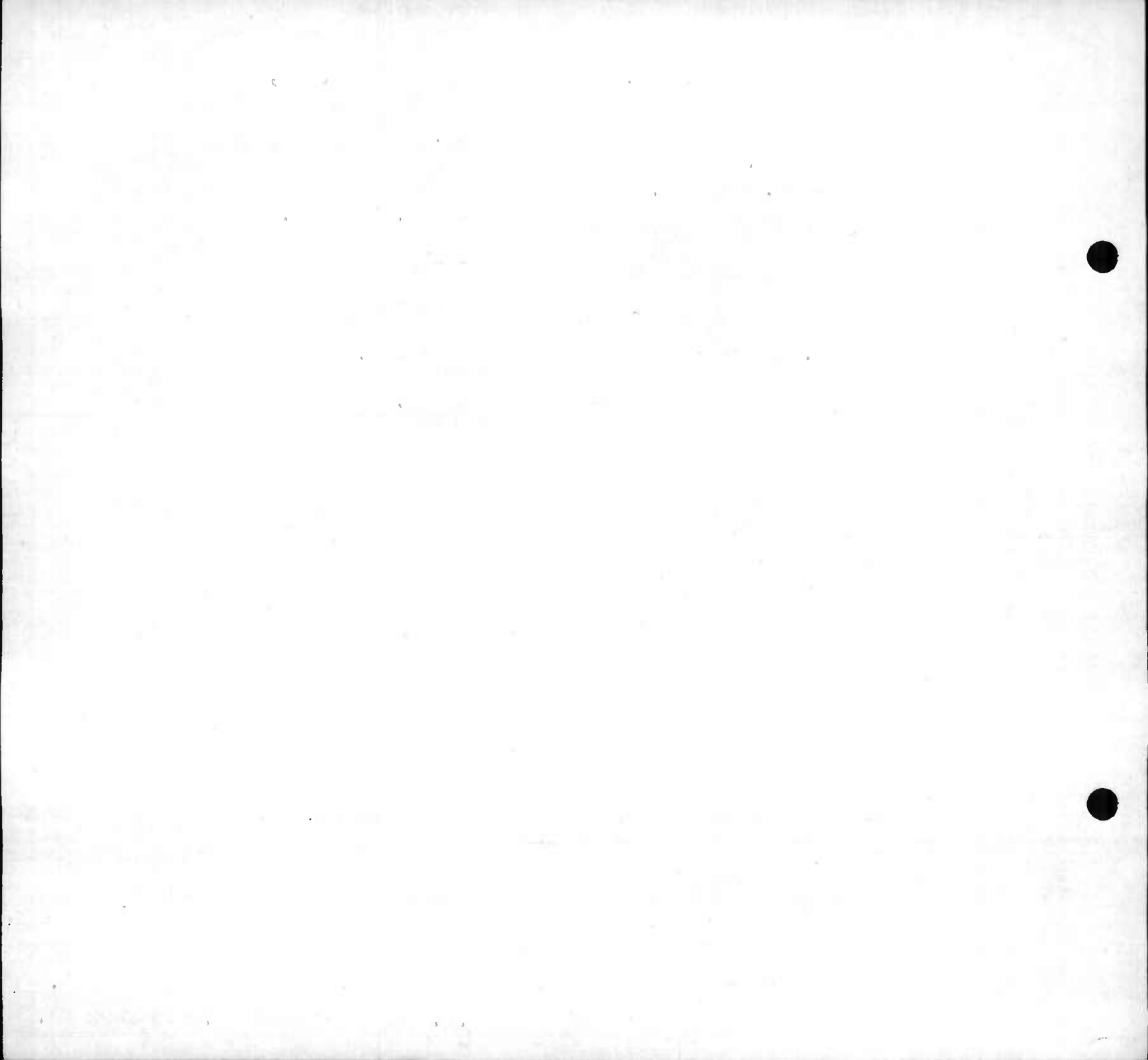
BIRTH NO. M.E. CASE NO.		66 00793		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00793	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
BONNIE JO MILLS				1-20-66 835 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
33 JOHNS HOPKINS HOSPITAL				MARYLAND			
5. SEX				6. DATE OF BIRTH			
FEMALE				2-12-10			
6. RACE		7. MARRIED, NEVER MARRIED		9. AGE (In years)		10. If Under 1 Yr. Months: Days	
WHITE		WIDOWED, DIVORCED (specify)		lost birthday		If Under 24 Hrs. Hours: Min.	
		MARRIED		55			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
Housewife				Texas			
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?			
Own Home				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
T. CARL POOLE				SUE M. CORBEL			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		212-46-7599		Louis R. Mills		(Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES				DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
				Interval BETWEEN ONSET AND DEATH			
				10 days			
				2 days			
				2 years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Recurrent Small Bowel Obstruction & Ileostomy			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (1) (this hospital) attended the deceased from 1-18-66 to 1-20-66, that (1) (we) last saw the deceased alive on 1-20-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
MICHAEL A. DAVIS						1-20-66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
MICHAEL A. DAVIS				JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Entombment		1/24/66		Dulaney Valley Mem. Grds.		Timonium, Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 24 1966		E. F. Jenkins		H.W. Jenkins & Sons Co.		4905 York Rd. Balto. 12, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

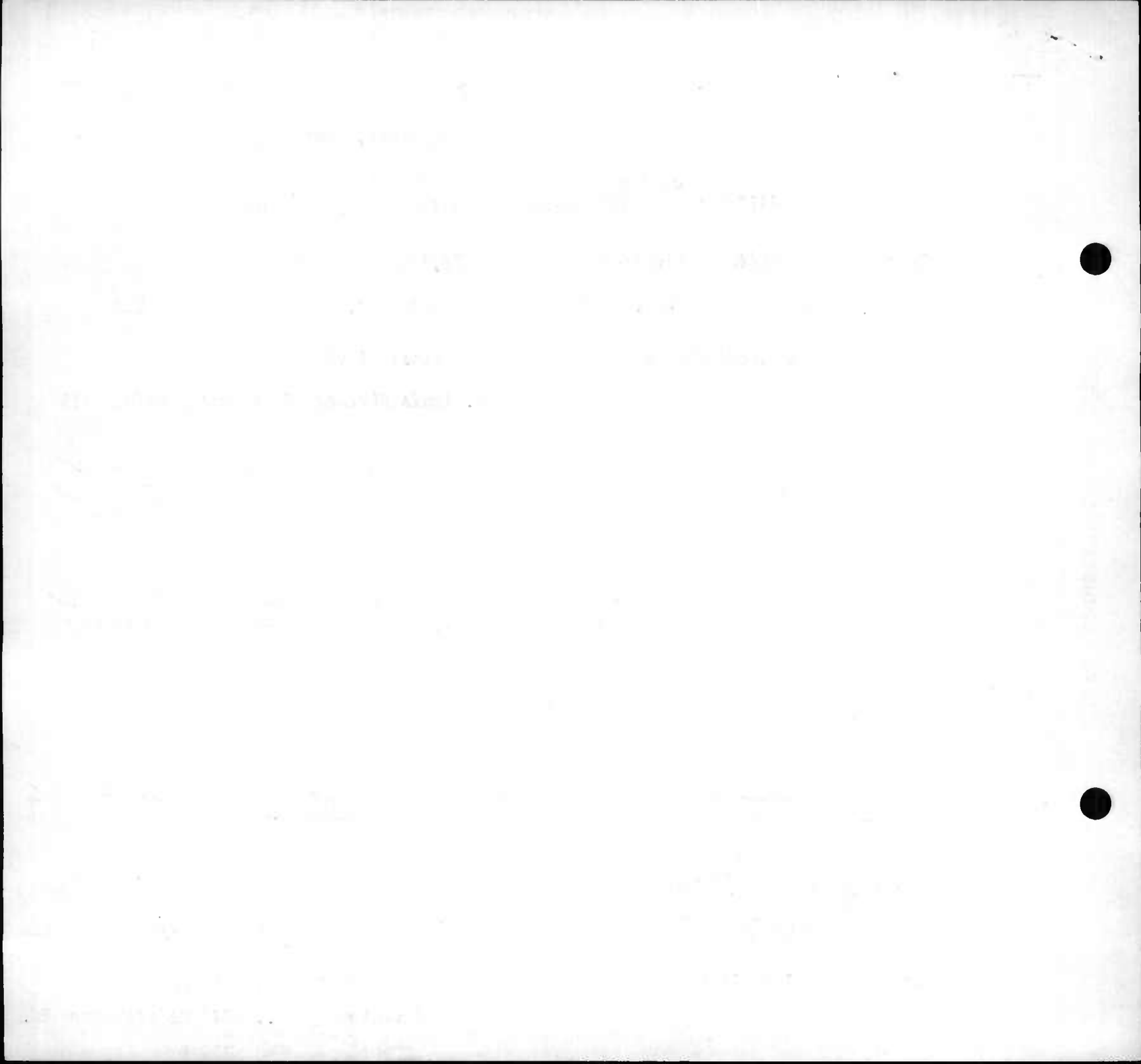
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 00794					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 66 00794				
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
FLORENCE L. HANN					JAN. 21, 1966 7:00 p.m.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY				
102 W. 39th St.					Md. 12-01				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					Baltimore				
					D. STREET ADDRESS (If rural, give location)				
					102 W. 39th St.				
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)	
F		W		Widowed		2-8-1883		82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife				Own Home		Maryland		USA	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Charles E. Baker					Harriet S. Whiteley				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No					--		Emma R. Baker Above		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					(A) Carcinoma of ovary with metastases				
INTERVAL BETWEEN ONSET AND DEATH					Nov 24				
ANTECEDENT CAUSES					(B) DUE TO				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C) DUE TO				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
O									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?				
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (the hospital) attended the deceased from 1955 to Jan 21, 1966, that (I) (we) last saw the deceased alive on Jan 21, 5:30 PM, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					23B. DATE SIGNED				
John A. Nesbitt Jr.					Jan 22, 66				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
JOHN A. NESBITT JR.					1009 Frederick Rd., Baltimore Md 21228				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)	
Burial		1-24-66		Loudon Park		Baltimore		Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR			ADDRESS		
JAN 24 1966		R. L. B. Jenkins		H. W. Jenkins & Sons Co.			4905 York Rd.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>66 00795</u>	
BIRTH NO. <u>66 00795</u>		M.E. CASE NO. <u>66 00795</u>		1. NAME OF DECEASED (Type or Print) <u>LILLIAN S. SHOCHET</u>		2. DATE AND HOUR OF DEATH <u>Jan 23, 1966</u> <u>1</u> <u>A</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Mt Sinai Nursing Home</u> <u>4613 Park Heights Avenue</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Baltimore, Maryland</u> B. COUNTY <u>27-16</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>4613 Park Heights Avenue</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Divorced</u>	8. DATE OF BIRTH <u>8/26/1896</u>	9. AGE (In years last birthday) <u>69</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mordecai Shochet</u>				14. MOTHER'S MAIDEN NAME <u>Bessie Levin</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Mr. Louis Shochet 7058 Surrey Drive #15</u>			
18. <u>331X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral hemorrhage</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Generalized arteriosclerosis</u>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <u>Generalized arteriosclerosis</u>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Pneumotorial arthritis</u> <u>Generalized angina and senility</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>Several years</u>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>December 1965</u> to <u>January 22, 1966</u> , that (I) (we) last saw the deceased alive on <u>January 21, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Seymour H. Rubin</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>1/22/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Seymour H. Rubin</u>				23D. ADDRESS <u>5415 Park Heights Ave</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/23/1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>Beth Tfiloh</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 24 1966</u>		25B. NAME OF REGISTRAR <u>02-6-2-6-0-0-0</u>		25C. FUNERAL DIRECTOR <u>Sol Levinson & Bros.</u>		ADDRESS <u>6010 Reisterstown Rd.</u>	



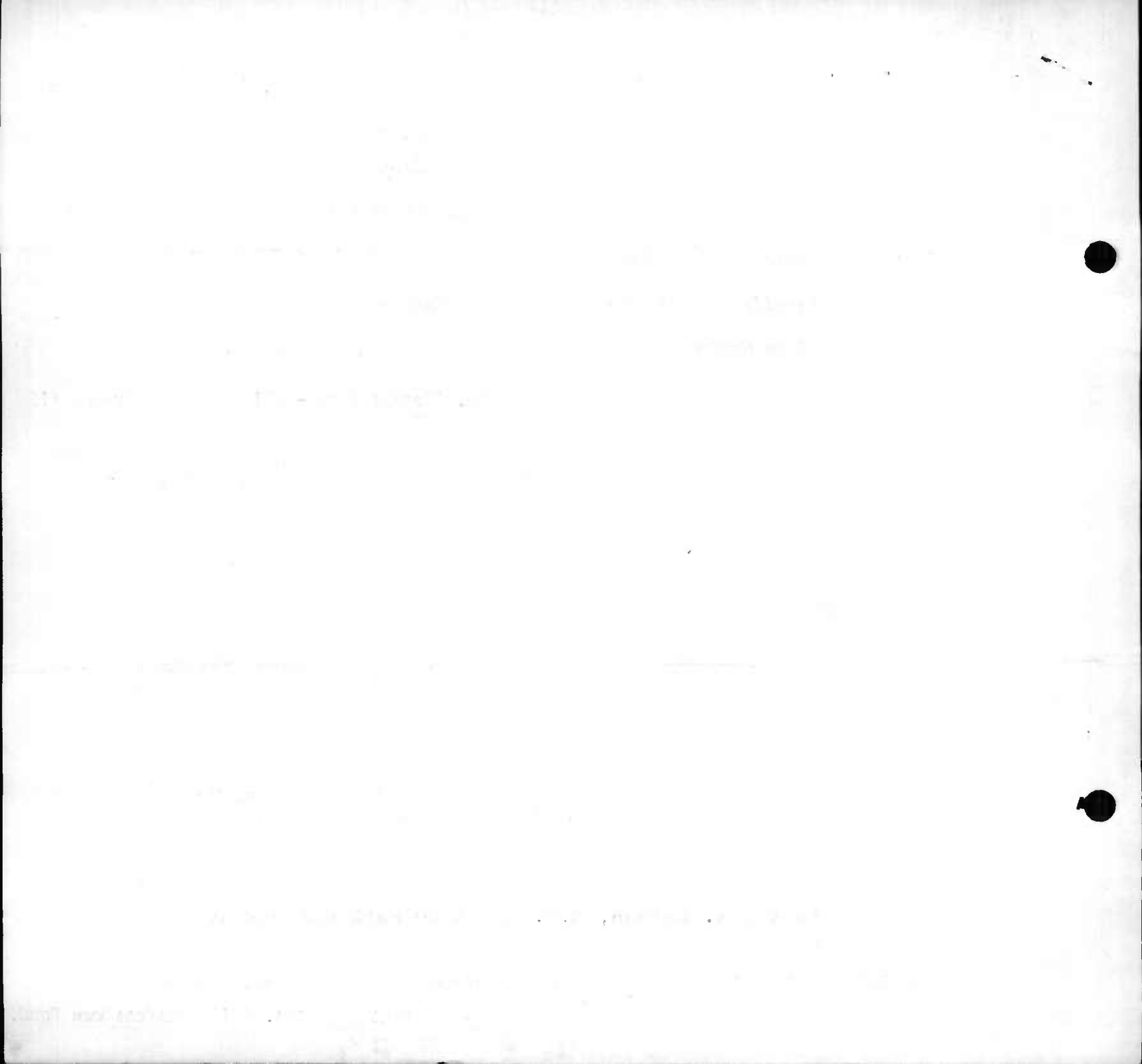
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 3-00796

BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				BESSIE MICHELSON		JANUARY 22, 1966 7:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital				A. STATE Maryland			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 3328 Clarks Lane			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow		8. DATE OF BIRTH 70		9. AGE (In years lost birthday) 70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Simon Gordon				14. MOTHER'S MAIDEN NAME Yetta Steinberg			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Florine Levy - 3712 Glengyle Avenue #15			
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Acute Myocardial Infarct 1 day</u> DUE <u>to this chronic CVD</u> (B) _____ DUE TO _____ (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>20 yr</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Nov 13 1954</u> to <u>Jan 22 1966</u> , that (I) (we) last saw the deceased alive on <u>Jan 21 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Lester N. Kolman</u> M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>1/22/66</u>	
23C. PHYSICIAN'S NAME (Type) Lester N. Kolman, M.D.				23D. ADDRESS 3700 Park Heights Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/23/1966		24C. NAME OF CEMETERY OR CREMATORY Bnai Israel Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966		25B. NAME OF REGISTRAR <u>John A. Staley</u>		25C. FUNERAL DIRECTOR ADDRESS Sol Levinson & Bros. 6010 Reisterstown Road.			



BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 66 00797
M.E. CASE NO.MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 007971. NAME OF DECEASED
(Type or Print)

RAPHAEL (RAY) FREIDMAN

2. DATE AND HOUR PRONOUNCED DEAD

January 20, 1966 9:40 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

900 W. Saratoga Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3501 Clarks Lane

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

JULY 13, 1910

9. AGE (In years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Executive

10B. KIND OF BUSINESS OR INDUSTRY

General Wrecking Co.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Nathan Friedman

14. MOTHER'S MAIDEN NAME

Rose Dubois

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

219-05-8166

17. INFORMANT

Mrs. Jeannette Friedman

ADDRESS

3501 Clarks Lane

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A).....
DUE TO

Gunshot wound of head

II
ANTECEDENT CAUSESDISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B).....
DUE TO

(C).....

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUT-
ING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Storeroom

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

900 W. Saratoga St. - Rear Storeroom

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
1 20 66 8:00A

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Shot self in head

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-20-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1/21/1966

23C. NAME OF CEMETERY or CREMATORY

Chizuk Amuno

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JAN 24 1966

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Sol Levinson & Bros. 6010 Reisterstown Road

WALTON
POLICE

1951

1951

1951

1951

1951

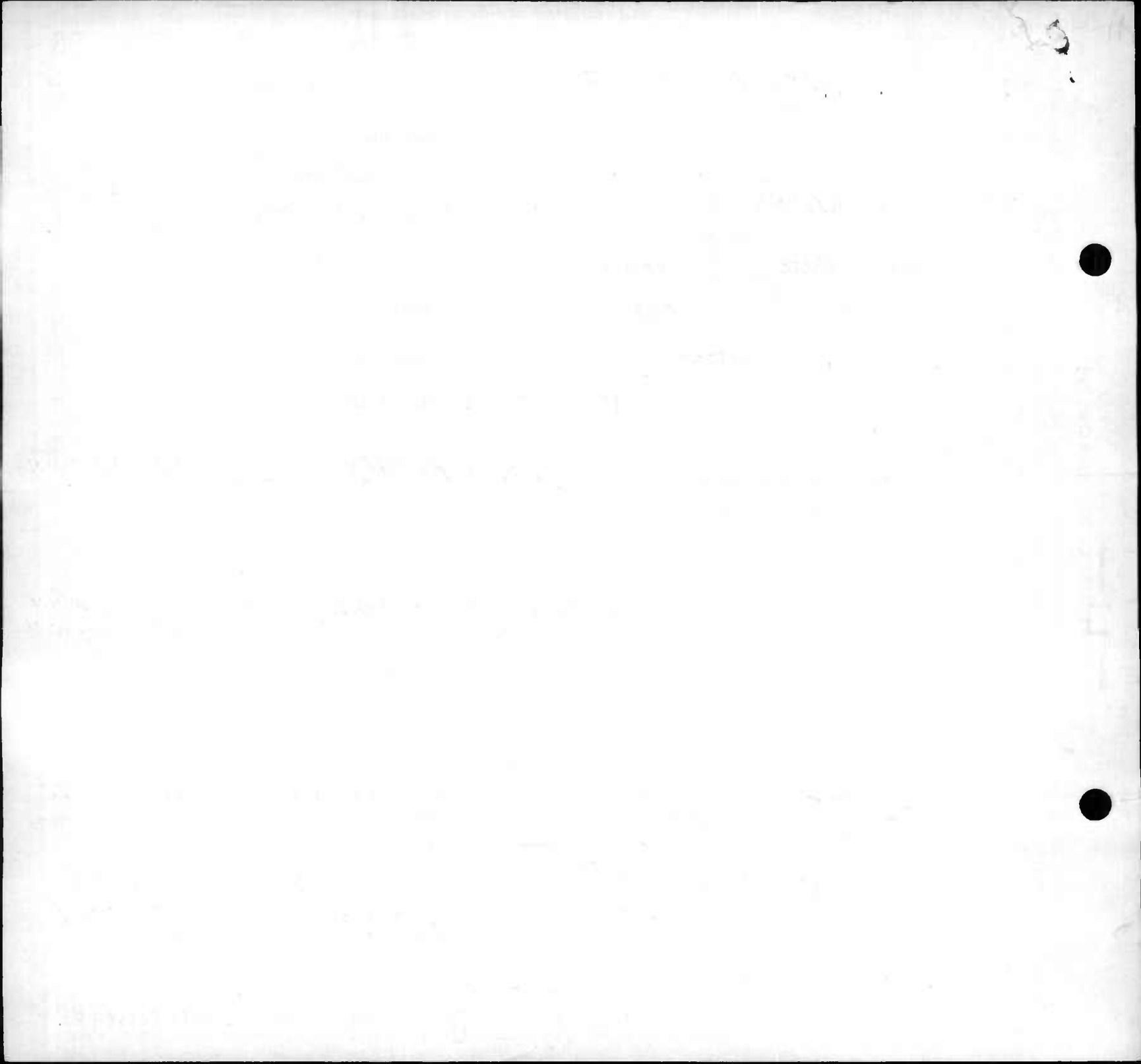
1951

1951

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 66 00738					CERTIFICATE OF DEATH					Registered No. 66 00738				
1. NAME OF DECEASED (Type or Print) JACOB HOLTZMAN					2. DATE AND HOUR OF DEATH 1/21/66 8.15 P. M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LEVINDALE HEBREW HOME & INFIRMARY					A. STATE B. COUNTY Maryland					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
					D. STREET ADDRESS (If rural, give location) Levindale Aged Home									
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH		9. AGE (In years last birthday) 84		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manuf				10B. KIND OF BUSINESS OR INDUSTRY Caps		11. BIRTHPLACE (State or foreign country) Russia				12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME ? Holtzman					14. MOTHER'S MAIDEN NAME Unknown									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. 217/09/8993		17. INFORMANT Sigmund Holtzman					ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH (A) BRONCHO PNEUMONIA					INTERVAL BETWEEN ONSET AND DEATH NOT KNOWN				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					ARTERIOSCLEROTIC HEART DISEASE					NOT KNOWN				
DIABETES MELLITUS										NOT KNOWN				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (H) (this hospital) attended the deceased from 5/25/1965 to 1/21/1966 that (H) (we) last saw the deceased alive on 1/21/1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.														
23A. SIGNATURE George Bercu, M.D.					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/21/66							
23C. PHYSICIAN'S NAME (Type) DR. GEORGE BERCU					M.D.		23D. ADDRESS LEVINDALE HEBREW HOME & INFIRMARY BALTIMORE MARYLAND.							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/23/66		24C. NAME OF CEMETERY or CREMATORY Anshe Emunah-Aitz Chaim			24D. LOCATION Baltimore, Maryland							
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1966					25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS INC. 6010 Reist Rd.							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

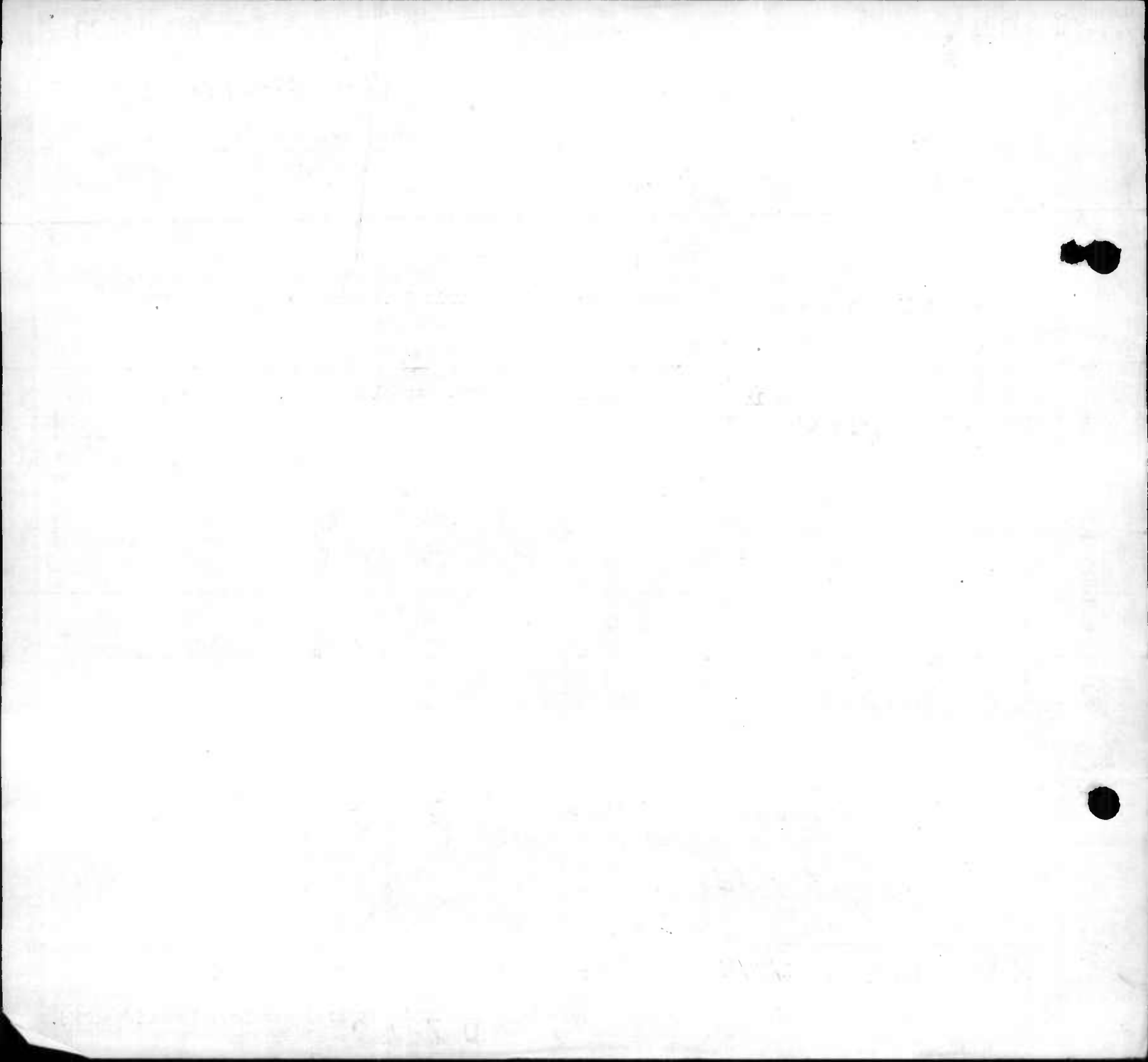
BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 66 00799					CERTIFICATE OF DEATH					Registered No. 66 00799				
M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) John J. Kveder					2. DATE AND HOUR OF DEATH Jan 23, 1966 1:17 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md B. COUNTY 22-02					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto 30				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4 Maryland General Hosp Balto. Md.					D. STREET ADDRESS (If rural, give location) 639 Washington Blvd.									
5. SEX M		6. RACE Cau		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 7/24/90		9. AGE (In years last birthday) 75		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) Lithuania				
12. CITIZEN OF WHAT COUNTRY? Lithuanian					13. FATHER'S NAME Andrew Kveder					14. MOTHER'S MAIDEN NAME Katherine				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No No					16. SOCIAL SECURITY NO. 215-03-0010					17. INFORMANT Katherine Kveder (wife)				
ADDRESS					ADDRESS					ADDRESS				
18. 199.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) AdenoCa, Neck DUE TO Metastasis (B) DUE TO (C) DUE TO					INTERVAL BETWEEN ONSET AND DEATH 2 yrs				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION 0					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) No				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (1) (this hospital) attended the deceased from 1/20 1966 to 1/23 1966, that (1) (we) last saw the deceased alive on 1/23 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.														
23A. SIGNATURE Donald T. Lewers M.D.										23B. DATE SIGNED 1/23/66				
23C. PHYSICIAN'S NAME (Type) Donald T. Lewers M.D.										23D. ADDRESS Maryland Gen Hosp Balto Md				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 1/26/1966		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem			24D. LOCATION (City, town, or county) (State) Balto Md				
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1966					25B. NAME OF REGISTRAR John E. Taylor M.D.					25C. FUNERAL DIRECTOR Thomas J. Kenny Inc 1600 Hollins				
ADDRESS					ADDRESS					ADDRESS				

[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 66 00800					CERTIFICATE OF DEATH					Registered No. 66 00800				
1. NAME OF DECEASED (Type or Print) RANDOLPH W. McGEE										2. DATE AND HOUR OF DEATH Jan. 22-1966 1:20 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY DORCHESTER C. CITY OR TOWN (If outside city limits, write RURAL and give township) EAST NEW MARKET D. STREET ADDRESS (If rural, give location) ROUTE # 1									
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 4-20-14		9. AGE (In years last birthday) 51		10. If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Field Supervisor					10B. KIND OF BUSINESS OR INDUSTRY Frozen Food					11. BIRTHPLACE (State or foreign country) Harris Co., Georgia		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Ira Q. McGee					14. MOTHER'S MAIDEN NAME EULA IRVIN									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II					16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Randolph McGee, Secretary, Maryland					ADDRESS		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Generalized Sepsis Septic emboli Thrombophlebitis INTERVAL BETWEEN ONSET AND DEATH Approx 12 hrs 25 days														
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 1) Intestinal Obstruction 2) Pulmonary Embolus 3) Fungal Pneumonia														
20A. DATE OF OPERATION 1/17/66					20B. CONDITION FOR WHICH OPERATION WAS PERFORMED A) Intestinal Obstr. B) Pulmonary Embolus					20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 12/30 1965 to 1/22 1966, that (I) (we) last saw the deceased alive on 1/22 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE Robert A. Ratchison										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/22/66		
23C. PHYSICIAN'S NAME (Type) ROBERT A. RATCHISON					23D. ADDRESS THE JOHNS HOPKINS HOSPITAL									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/27/66		24C. NAME of CEMETERY or CREMATORY New Hope Cemetery			24D. LOCATION (City, town, or county) (State) Brandon, Florida							
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1966		25B. NAME OF REGISTRAR L. E. E. E. E.			25C. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Md.			ADDRESS						



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such approval must be obtained before the remains are embalmed or final disposition is made.

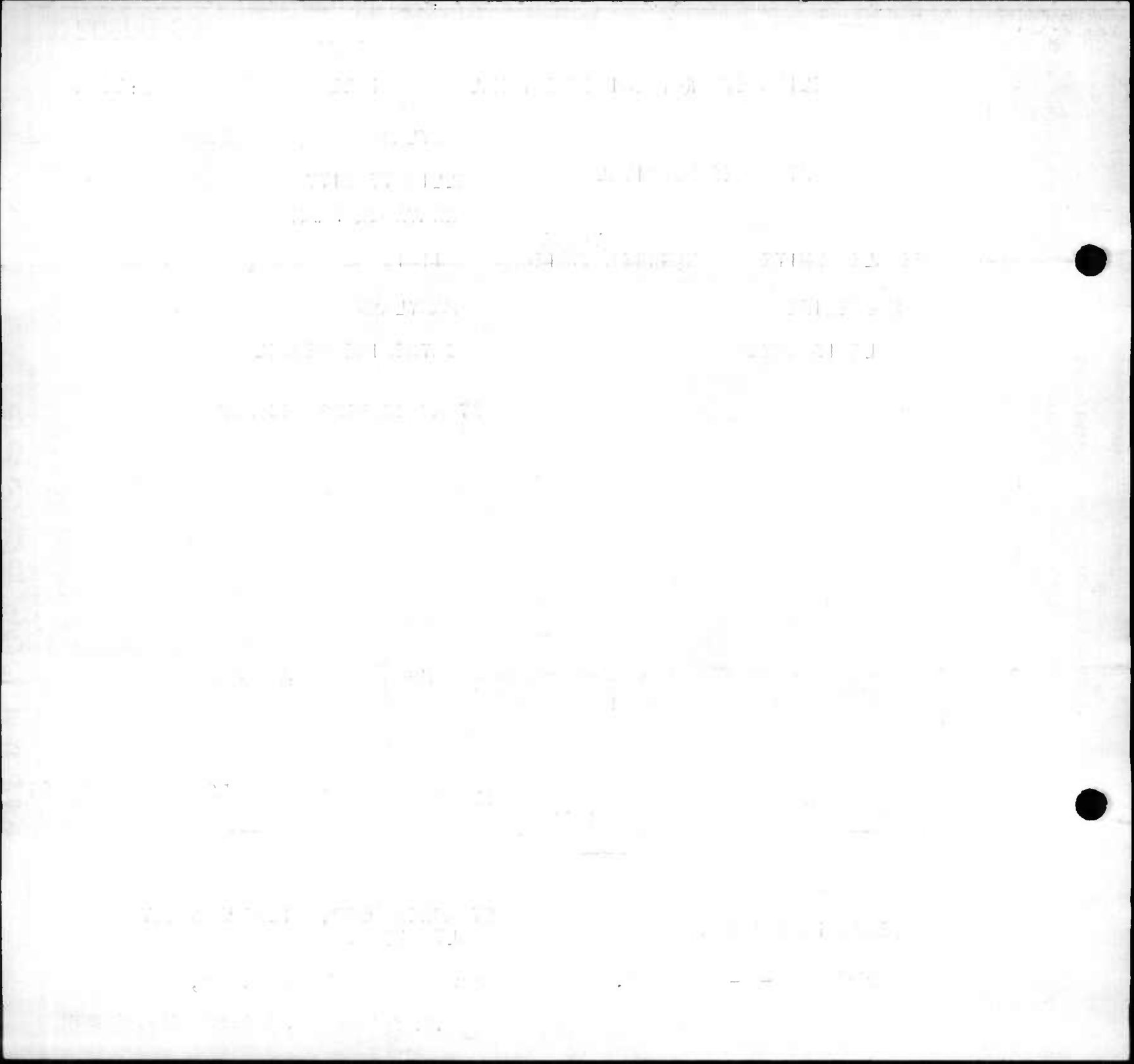
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <u>66 00801</u>				
BIRTH NO. <u>66 00801</u>									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <u>Kelson, Christ</u> (Christ Kelson)					2. DATE AND HOUR OF DEATH <u>11/23/66</u> <u>2:45</u> P. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <u>The Union Memorial Hospital</u> (If not in hospital or institution, give street address or location)					A. STATE <u>Maryland</u>				
					B. COUNTY <u>12-06</u>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>				
					D. STREET ADDRESS (If rural, give location) <u>54 E. 26th St.</u>				
5. SEX <u>Male</u>	6. RACE <u>Caucasian</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>6/9/90</u>		9. AGE (In years last birthday) <u>75</u>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired Sail Maker</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Coast Guard</u>		11. BIRTHPLACE (State or foreign country) <u>Norway</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anders Kelson</u>					14. MOTHER'S MAIDEN NAME <u>Annette</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>W.W.1</u>			16. SOCIAL SECURITY NO. <u>115-09-5333</u>		17. INFORMANT <u>Mrs. Gertrude Kelson</u>			ADDRESS <u>Same as above</u>	
18. <u>410X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>RHEUMATIC HEART DISEASE</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>WITH AORTIC STENOSIS</u> <u>MYOCARDIAL INFARCTION</u> <u>CONGESTIVE HEART FAILURE</u>					CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>2</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES.</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that <u>(A)</u> (this hospital) attended the deceased from <u>1-22-</u> 19 <u>66</u> to <u>1-23</u> 19 <u>66</u> , that <u>(A)</u> (we) last saw the deceased alive on <u>1-23</u> 19 <u>66</u> and that in <u>(A)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(A)</u> (We) (did) <u>(A)</u> view the body after death.									
23A. SIGNATURE <u>A. C. Tipton, Jr.</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>1/23/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR. ANCEL C. TIPTON, JR.</u>					23D. ADDRESS <u>33rd + Calvert Sts.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>			24B. DATE <u>1-25-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Lake View</u>		24D. LOCATION (City, town, or county) (State) <u>near Sykesville, Carroll Co. Md</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1966</u>			25B. NAME OF REGISTRAR <u>Philip E. Sisk</u>			25C. FUNERAL DIRECTOR ADDRESS <u>Stewart & Mowen Co. 108-W-North Av (21201)</u>			

U. S. GOVERNMENT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

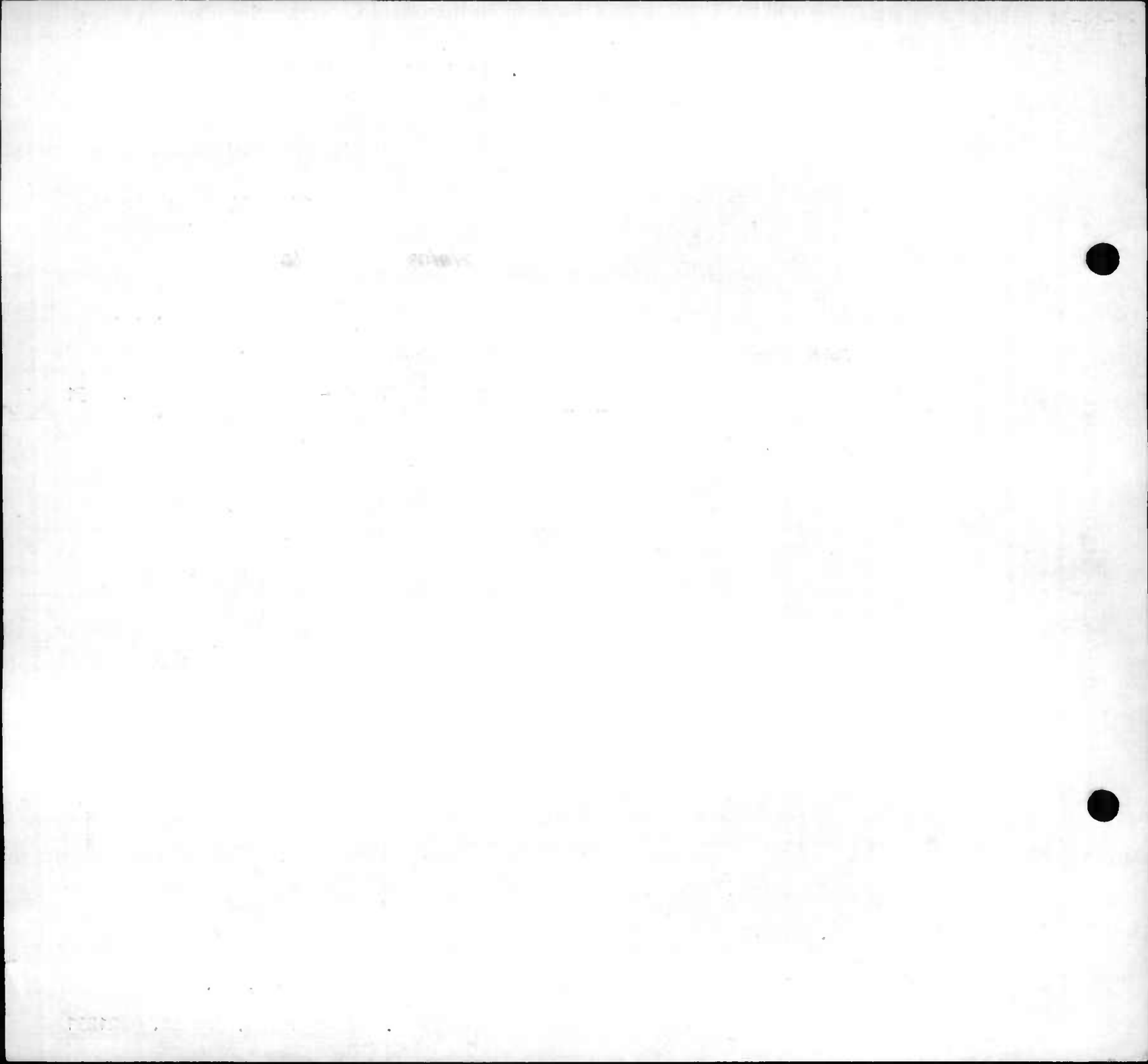
BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 66 00802					CERTIFICATE OF DEATH					Registered No. 66 00802				
M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) ELIZABETH KATHERINE WESTPHAL					2. DATE AND HOUR OF DEATH 1 22 66 9:20 A M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY HOWARD					C. CITY OR TOWN (If outside city limits, write RURAL and give township) ELLICOTT CITY 6300				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL					D. STREET ADDRESS (If rural, give location) GRAYROCK FARM									
5. SEX FEMALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED NEVER MARRIED RE-MARRIED		8. DATE OF BIRTH 11 10 86		9. AGE (In years last birthday) 79		10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) MARYLAND				
12. CITIZEN OF WHAT COUNTRY?					13. FATHER'S NAME LEWIS SPIES					14. MOTHER'S MAIDEN NAME CATHERINE WENDEL				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. None					17. INFORMANT ST AGNES HOSP RECORDS				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 15-3.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH (A) DUE TO Carcinoma of the caecum with Acute Cardiac Failure & Terminal Emaciation (B) DUE TO (C)					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) NO				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initiate medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (X) (this hospital) attended the deceased from 12 19 65 to 1 22 66, that (X) (we) lost saw the deceased alive on 1 22 66 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.														
23A. SIGNATURE Benjamin C. Guzman M.D.										23B. DATE SIGNED 1-22-66				
23C. PHYSICIAN'S NAME (Type) BENJAMIN C GUZMAN M.D.										23D. ADDRESS ST AGNES HOSP, WILKENS & CATON BALTO 29 MD				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 1-25-66					24C. NAME of CEMETERY or CREMATORY St. Johns Lutheran				
24D. LOCATION Pfeiffers Corner, Md					24E. (City, town, or county) (State)									
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1966					25B. NAME OF REGISTRAR O. R. Higinbotham					25C. FUNERAL DIRECTOR O. R. Higinbotham, Ellicott City, Md				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

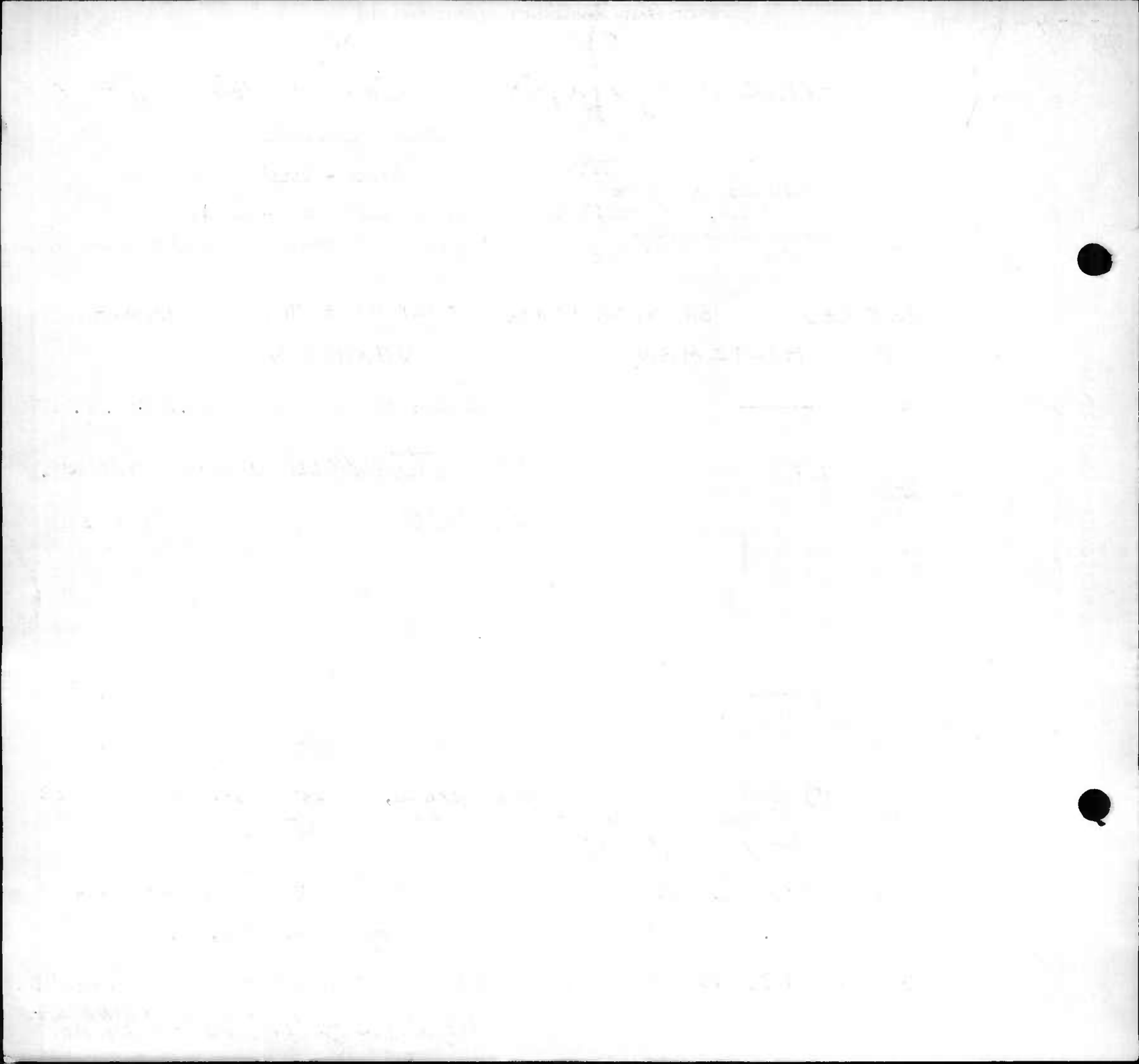
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 00803	
BIRTH NO. 66 00803		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Frances Skalinski		2. DATE AND HOUR OF DEATH Jan 23 1966 19⁴⁰ P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 203 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1902 Aliceanna Street 4940 EASTERN AVENUE #21224			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2/9/03	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Packing House		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Buczek				14. MOTHER'S MAIDEN NAME Frances Hezek (Hizik)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-09-6287		17. INFORMANT ADDRESS Frank Skalinski - 1902 Aliceanna St. #32 RECORDS: BCH 4940 EASTERN AVE. #21224			
18. 493X-260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus, CVA.				CAUSE OF DEATH (A) Pneumonia DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 1 wk.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? #	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Dec 15 19 59 to Jan 23 19 66 , that (I) (we) last saw the deceased alive on Jan 23 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dr. Kenneth Tucker				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-23-66	
23C. PHYSICIAN'S NAME (Type) DR. KENNETH TUCKER				23D. ADDRESS M.D. 4940 EASTERN AVENUE #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/27/66		24C. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1966		25B. NAME OF REGISTRAR George A. Weber		25C. FUNERAL DIRECTOR ADDRESS 705 S. Ann St. #21231			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

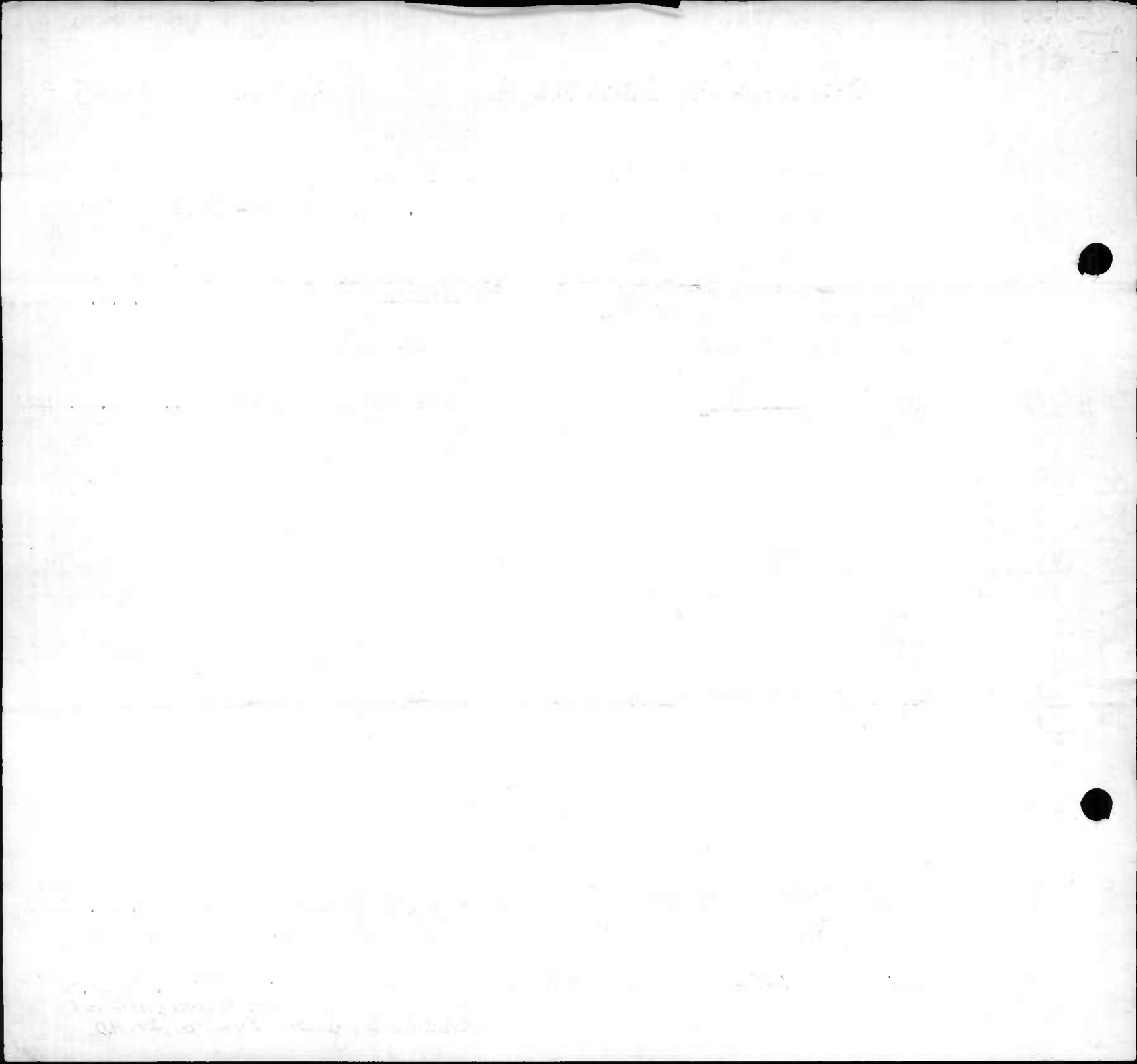
BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00804	
BIRTH NO. 66 00804		CERTIFICATE OF DEATH	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Frank Holtzman, SR.		2. DATE AND HOUR OF DEATH Jan 19, 1966 8 ³⁵ A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224		A. STATE MARYLAND B. COUNTY BALTIMORE	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Essex - Rural	
		D. STREET ADDRESS (If rural, give location) 374 Nicholson Road - 21224	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH 4/2/79
		9. AGE (In years last birthday) 86	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY BALTO, CO, WORKER	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ? HOLTZMAN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. RECORDS: BCH 4940 Eastern Ave., Balto, Md. 21224	
17. INFORMANT ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH	
19. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(A) Congestive Heart Failure hours.	
		(B) ASCUD. years.	
		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		GI bleed.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED	
21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from Jan 1 Dec 20, 1965 to Jan 19 1966, that (2) (we) lost saw the deceased alive on Jan 19 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Kenneth R. Tucker		23B. DATE SIGNED 1-19-66	
23C. PHYSICIAN'S NAME (Type) Kenneth R. Tucker		23D. ADDRESS 4940 Eastern Avenue, Balto, Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-22-66	
24C. NAME OF CEMETERY or CREMATORY OAK LAWN CEM.		24D. LOCATION 7225 EASTERN BLVD. BA. CO., MD.	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1966		25B. NAME OF REGISTRAR Charles E. Taylor	
25C. FUNERAL DIRECTOR Charles E. Taylor		25D. ADDRESS 4015 CONKLING ST. BALTO., MD.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

45-62-7821		BALTIMORE CITY HEALTH DEPARTMENT		66 00805	
BIRTH NO. 66 00805		CERTIFICATE OF DEATH		Registered No. 66 00805	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Dobrzykowski, Catherine, A.		1-20-66 12:05 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY 2-03	
BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 706 S. DURHAM STREET - 21231			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8/23/12	9. AGE (In years last birthday) 53	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HARRY FORRESTER		14. MOTHER'S MAIDEN NAME WHITE, MARY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -----		17. INFORMANT RECORDS: BCH 4940 Eastern Ave., Balto. Md. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 323X I ACUTE BACTERIAL ENDOCARDITIS		CAUSE OF DEATH (A) DUE TO Acute bacterial endocarditis		INTERVAL BETWEEN ONSET AND DEATH 1 week	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Pneumococcal pneumonia		3 weeks	
		(C) DUE TO Bronchitis		2 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		ASCVD		years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 19 66 to 1-20 19 66, that (N) (we) last saw the deceased alive on 1-20 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas J. Jiles		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-20-66	
23C. PHYSICIAN'S NAME (Type) Thomas Jiles		23D. ADDRESS 4940 Eastern Avenue, Balto, Md. 21224 M.D. 537 W. Washington Street			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-24-66		24C. NAME OF CEMETERY or CREMATORY Sacred Heart Cemetery	
		24D. LOCATION (City, town, or county) (State) 7401 German Hill Rd. Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1966		25B. NAME OF REGISTRAR Charles E. Jiles		25C. FUNERAL DIRECTOR Charles E. Jiles	
		ADDRESS 901 S. CONKLING ST. BALTO., MD.			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARGARET E. SULLIVAN

2. DATE AND HOUR PRONOUNCED DEAD

January 20, 1966 7:40 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

~~Baltimore~~ Eastwood - Rural 33-00

D. STREET ADDRESS (If rural, give location)

627 S. 47th Street 21224

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

9-18-13

9. AGE (In years
last birthday)

58 52

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housework

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Pittsburgh, Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Christopher Pfeifer

14. MOTHER'S MAIDEN NAME

Anna Bevans

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

James Sullivan 627 S. 47th. Street 21224

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-20-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1-24-66

23C. NAME OF CEMETERY or CREMATORY

Sacred Heart Cemetery

23D. LOCATION

(City, town, or county)

(State)

7401 German Hill Rd. Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

JAN 25 1966

24B. NAME OF REGISTRAR

Robert E. Sullivan

24C. FUNERAL DIRECTOR

Charles S. Petty

ADDRESS

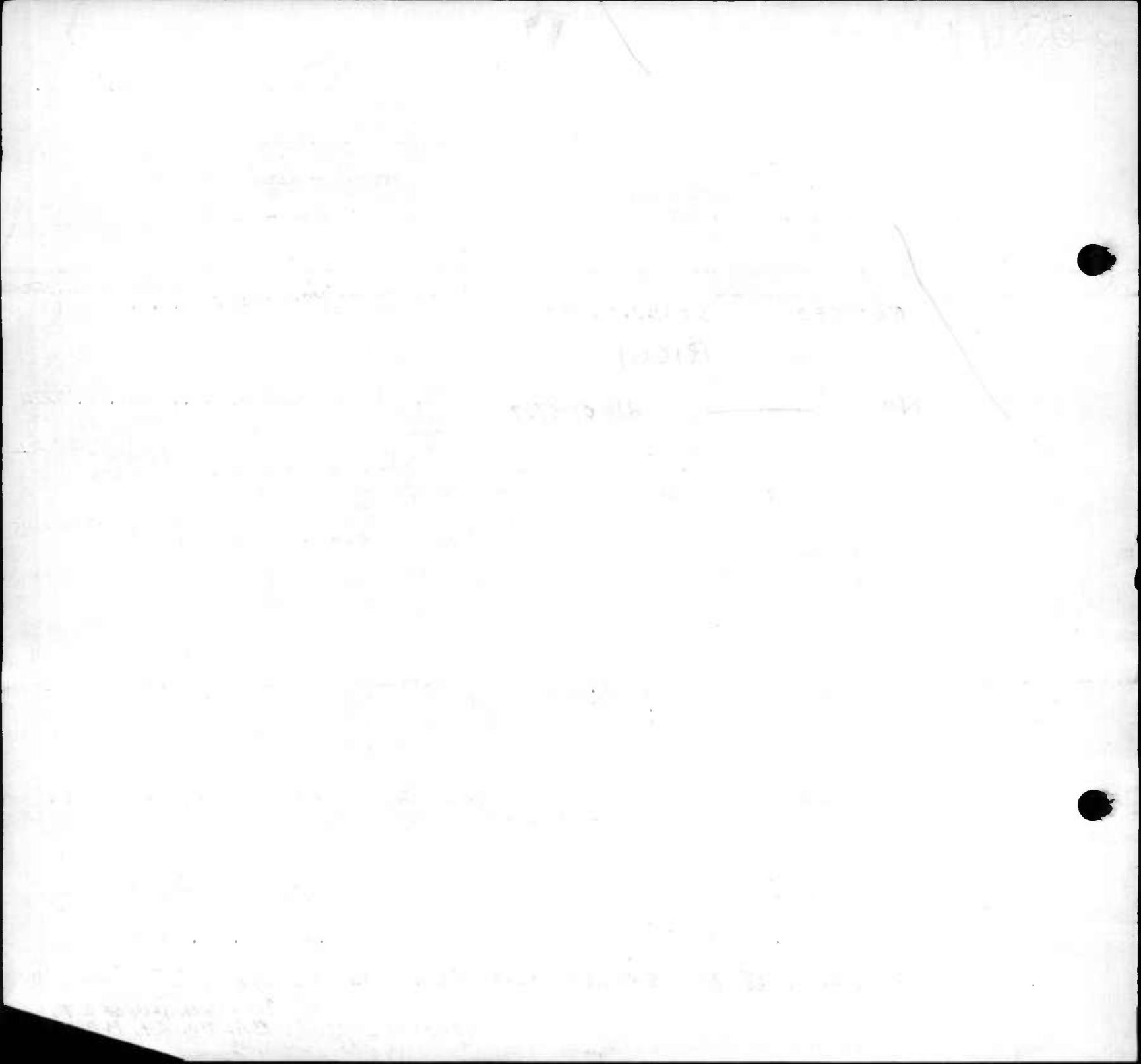
6224 EASTERN AVE.
BALTO., MD.

WALLACE R. FORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00807	
BIRTH NO. 66 00807		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH 1/21/66 10:45 A.M.	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Ricci, John, SR.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) Dundalk - Rural 53-00 D. STREET ADDRESS (If rural, give location) 6919 Delvale Place - 21222	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 3/10/87	9. AGE (In years last birthday) 78	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY STAND.OIL CO.		11. BIRTHPLACE (State or foreign country) RHODE ISLAND, PROVIDENCE	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME UNKNOWN RICCI		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-07-0727		17. INFORMANT ADDRESS RECORDS, BCH 4940 Eastern Ave., Balto. Md. 21224	
18. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) CARDIAC ARRHYTHMIA DUE TO ANOXIA		MOMENT OF DEATH	
ANTECEDENT CAUSES		(B) CVA DUE TO CEREBRAL ARTERIOSCLEROSIS		LONG STANDING	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 21 1966 to Jan 21 1966, that (I) (we) lost saw the deceased alive on Jan 21 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Leonard J. Quadracci		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Jan 21, 1966	
23C. PHYSICIAN'S NAME (Type) Leonard J. Quadracci		23D. ADDRESS M.D. 4940 Eastern Ave., Balto. Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-25-66		24C. NAME OF CEMETERY or CREMATORY SACRED HEART CEM	
24D. LOCATION 7401 GERMAN HILL RD., BALTO.		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1966		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR 901 S. CONKLIN BALTO. 24	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>66 00808</u>	
BIRTH NO. <u>66 00808</u>							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <u>MAX W. DEMSKI</u>				2. DATE AND HOUR OF DEATH <u>Jan. 20, 1966 2:20 P. M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>90 HARFORD GARDENS</u>				A. STATE <u>MARYLAND</u>			
				B. COUNTY <u>105</u>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
				D. STREET ADDRESS (If rural, give location) <u>326 S. PATTERSON PK. AVE</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>7-9-1899</u>	9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>MARTIN DEMSKI</u>				14. MOTHER'S MAIDEN NAME <u>NORA DZIEDZIC</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MARY DEMSKI</u>		ADDRESS <u>326 S. PATTERSON PK. AVE</u>	
18. I <u>4-22-1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Cerebral Vascular Accident</u> DUE TO (B) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 4</u> 19 <u>66</u> to <u>Jan 20</u> 19 <u>66</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>Jan 20</u> 19 <u>66</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>we</u>) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Loy M. Zimmerman</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>Jan 22, 66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Loy M. Zimmerman</u>				23D. ADDRESS <u>3202 Harford Rd, Baltimore, Md</u>			
24A. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>JAN 24-66</u>		24C. NAME OF CEMETERY OR CREMATORY <u>HOLY ROSARY</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>F.W. OZAZEWski</u>		ADDRESS <u>1930 EASTERN AVE</u>	

7-9-1871
POLAND

MORA DIEBIC

LABORER

MARTIN

NO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M. 4601

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 66 00809	
BIRTH NO. 66 00809 1487				DATE AND HOUR OF DEATH 1/23/66 1:30 A.M.			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Baby Boy Miller				2. DATE AND HOUR OF DEATH 1/23/66 1:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 University Hosp.				A. STATE Maryland B. COUNTY 13-05			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALT.			
				D. STREET ADDRESS (If rural, give location) 3014 DARBAY ST.			
5. SEX Male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) —	8. DATE OF BIRTH 1/14/66	9. AGE (In years last birthday) 9	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Carl Miller Jr.				14. MOTHER'S MAIDEN NAME JULIA LYNN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. —		17. INFORMANT chart		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) DUE TO Congenital Heart Disease (Aortic Valve Lesion)		INTERVAL BETWEEN ONSET AND DEATH Life	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) DUE TO			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 1/18/66 19 to 1/23/66 19, that (we) lost saw the deceased alive on 1/23/66 19 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did not) view the body after death.							
23A. SIGNATURE Edward J. Ruley, MD M.D.				23B. DATE SIGNED 23 Jan 1966			
23C. PHYSICIAN'S NAME (Type) Edward J. Ruley, MD M.D.				23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-25-66		24C. NAME OF CEMETERY OR CREMATORY LAKE VIEW MEM PARK		24D. LOCATION (City, town, or county) (State) BALT. MD	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Paul E. Charnick		ADDRESS 3617 Chestnut Ave	

Unusually High

Wife white -

Carl Miller Jr.

Wife

Carl

~~Carl Miller Jr.~~

Wife

Wife

Carl Miller Jr.

Carl

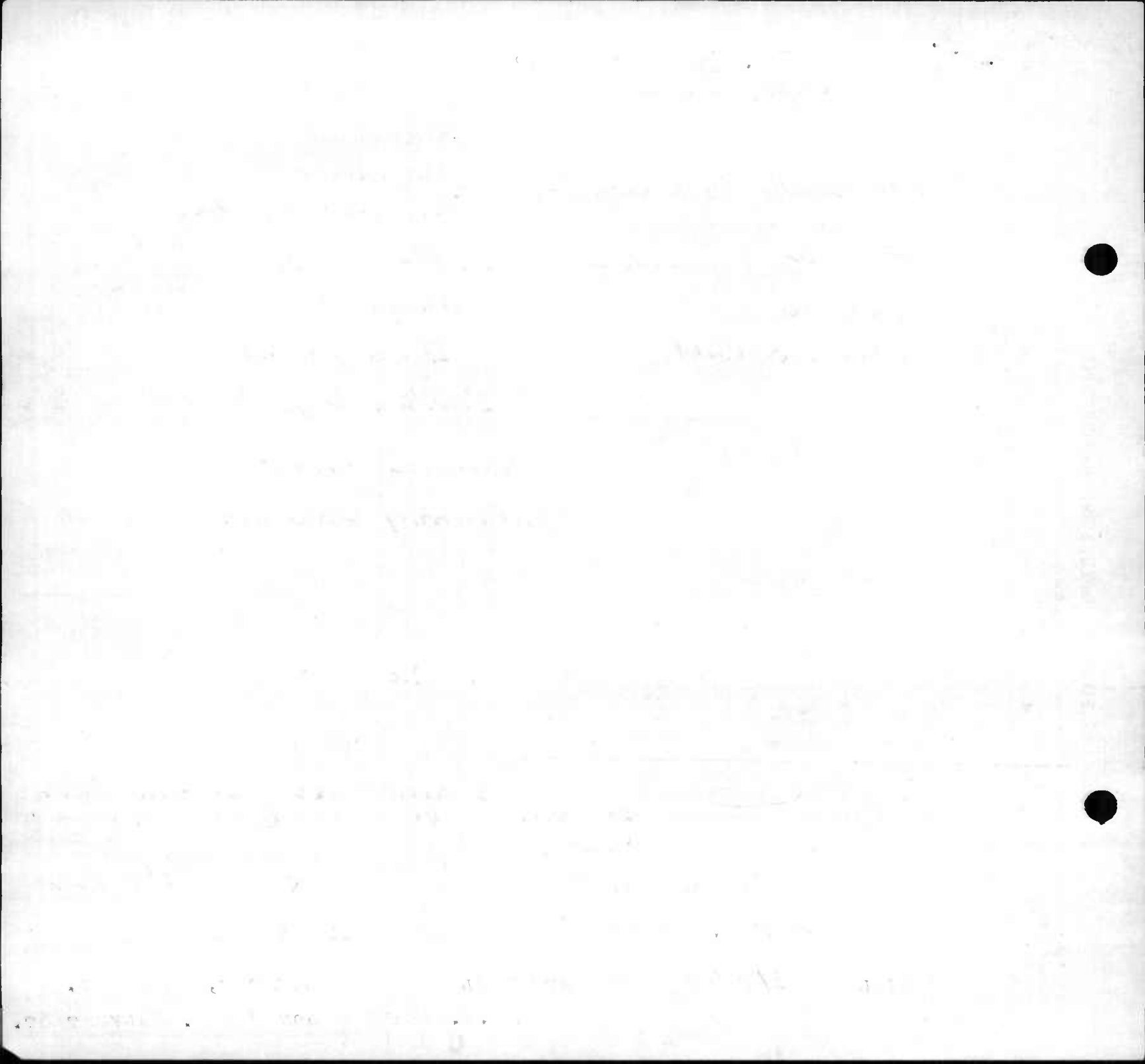
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FUNERAL DIRECTOR: IMPORTANT

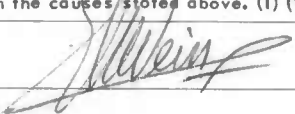
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 66 00810					CERTIFICATE OF DEATH					Registered No. 66 00810				
1. NAME OF DECEASED (Type or Print) MRS. IRENE CODD HEAPS										2. DATE AND HOUR OF DEATH 1/21/66 9:30 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 91 Montebello State Hospital										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-09 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1417 Winston Ave.				
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow		8. DATE OF BIRTH 10/2/1883		9. AGE (In years last birthday) 82		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.				
13. FATHER'S NAME William C. Codd						14. MOTHER'S MAIDEN NAME Irma Mohler								
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT S. Wilson Heaps, Jr.				ADDRESS 1223 Meridiana				
18. 465 XI DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardiac arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. pulmonary embolus immediate										CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?						
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>13 Jan</u> 19 <u>66</u> to <u>21 Jan</u> 19 <u>66</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>21 Jan</u> 19 <u>66</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> <u>(did not)</u> view the body after death.														
23A. SIGNATURE Robert W. Ireland M.D.								Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/21/66				
23C. PHYSICIAN'S NAME (Type) Robert W. Ireland						23D. ADDRESS Montebello State Hospital								
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/24/66		24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL				24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND.						
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1966				25B. NAME OF REGISTRAR Robert E. Talbot				25C. FUNERAL DIRECTOR ADDRESS H. W. MEARS & Son 805 N. CALVERT ST.						



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00811	
BIRTH NO. 66 00811		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH JANUARY 20, 1966 1:20P M.	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LEONARD, EDMUND THOMAS		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		(If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		D. STREET ADDRESS (If rural, give location) 108 MONTROSE AVE. #28	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2-28-08	9. AGE (In years last birthday) 57	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES		10B. KIND OF BUSINESS OR INDUSTRY SIDNEY POLAND CO		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME EDMUND T. LEONARD		14. MOTHER'S MAIDEN NAME MARY D. STANLEY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. 213-05-9606		17. INFORMANT ADDRESS ST. AGNES HOSP. RECORDS; CATON & WILKENS	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Heart rupture and tamponade DUE TO (B) Post. Myocardial Infarction DUE TO (C) ASCVD		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JANUARY 9 19 66 to JANUARY 20 19 66 , that (I) (we) last saw the deceased alive on JANUARY 20 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-20-66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D. ST. AGNES HOSPITAL; CATON & WILKENS AVE		#29	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 1-22-66		24C. NAME OF CEMETERY or CREMATORY Landon Park Crematory	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 25 1966		25B. NAME OF REGISTRAR L. E. Bailey, M.D.	
25C. FUNERAL DIRECTOR L. E. Bailey, M.D.		25D. ADDRESS 6600 E. ...			

ASCD
State Hospital
Hunt, Tipton and Langford

Yes

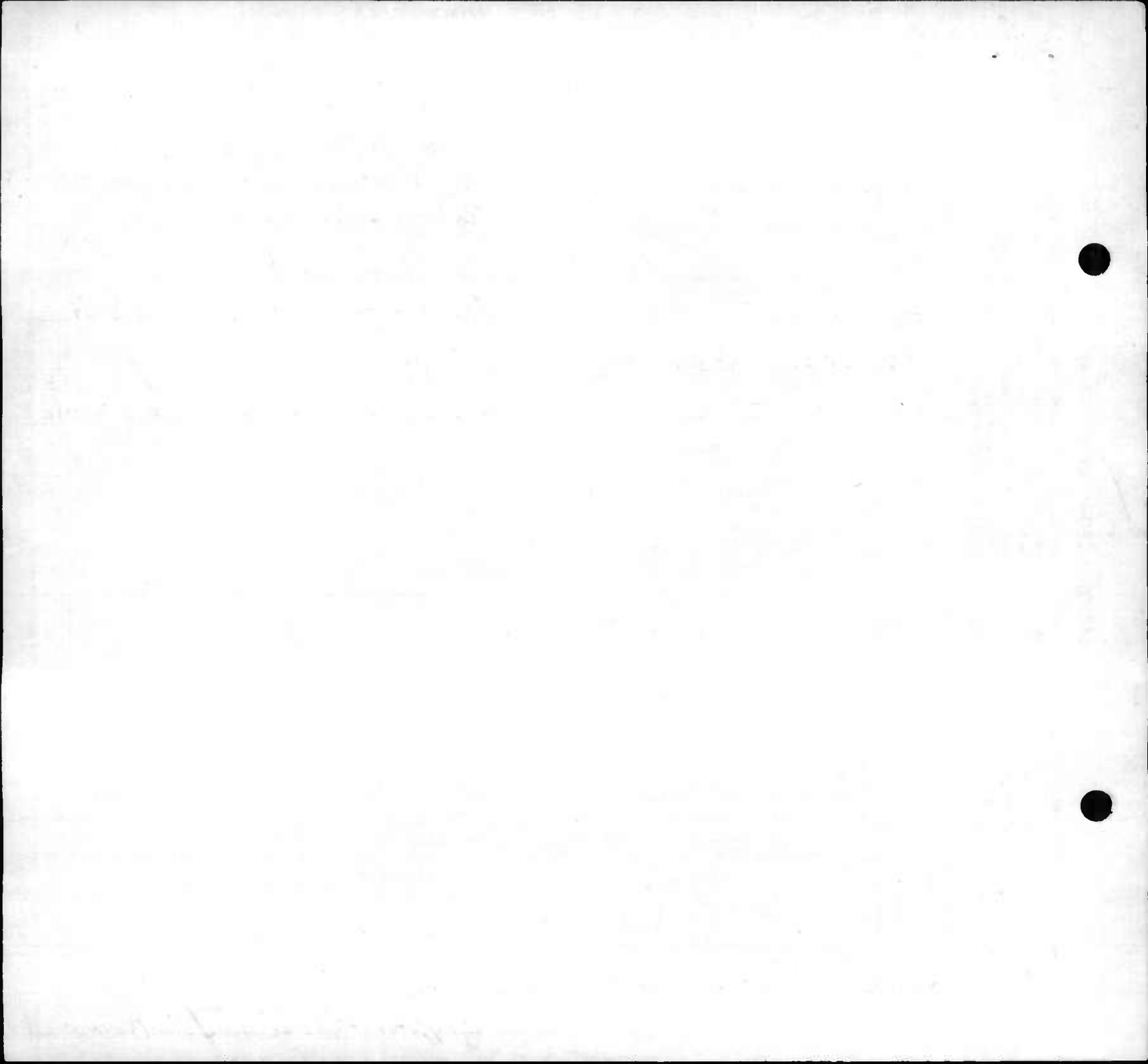
X

[Handwritten signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

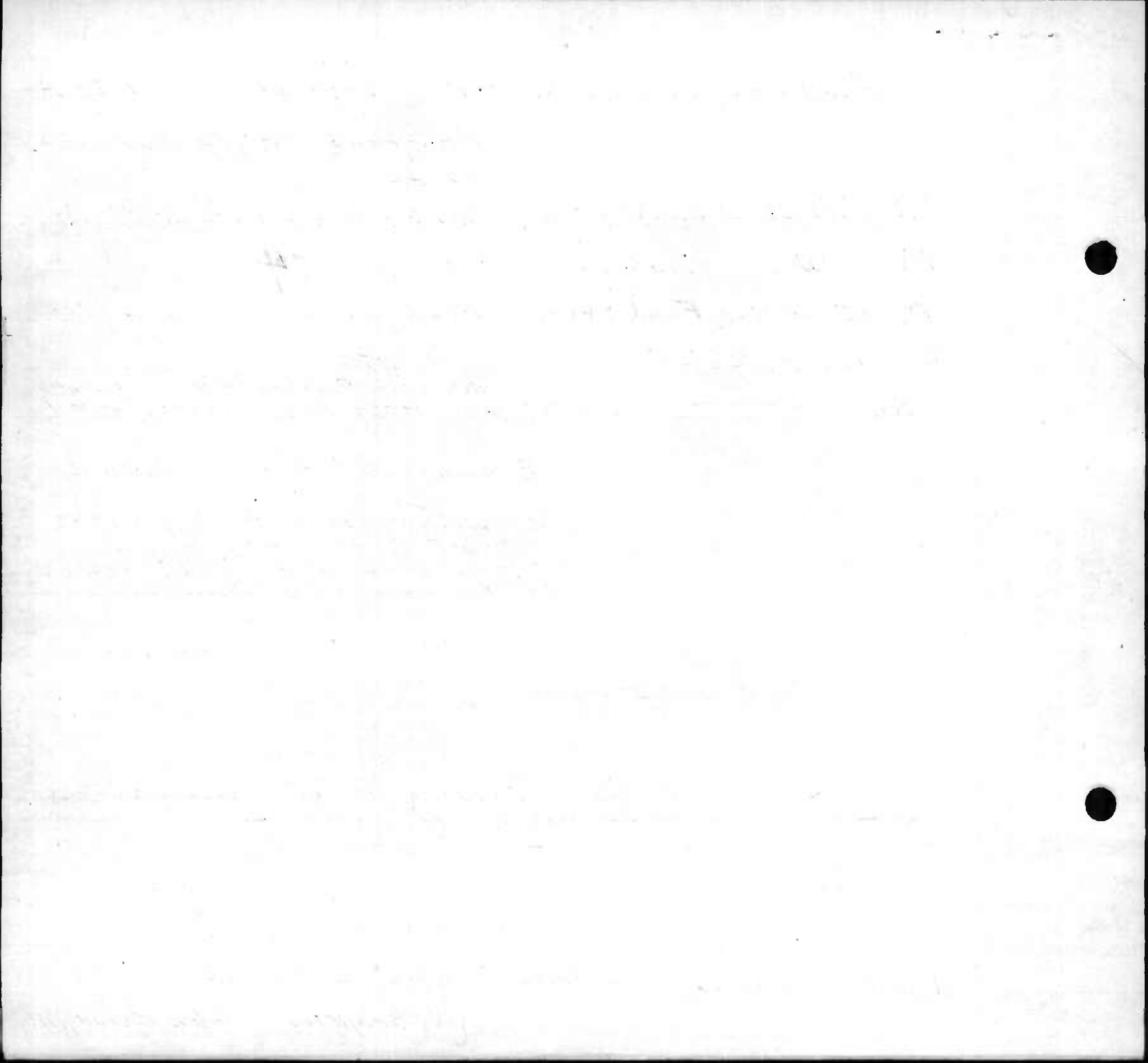
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 00812		CERTIFICATE OF DEATH		Registered No. 66 00812	
1. NAME OF DECEASED (Type or Print) ELSIE GUTMAN				2. DATE AND HOUR OF DEATH 21 Jan 1966 205 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-17 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore (Levindale Hebrew - Home) D. STREET ADDRESS (If rural, give location) Belldr. Greenspring Aves.					
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 29 June 1879		9. AGE (In years lost birthday) 86		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Baltimore, md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michel Rosenfeld				14. MOTHER'S MAIDEN NAME Carline Wiesenfeld					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT IRVING E. ROBINSON - 3813 - Monio, Dc. Balto, md.			
18. 493X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pneumonia				CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 4 days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Bronchitis & Emphysema									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that it (this hospital) attended the deceased from 20 Jan 1966 to 21 Jan 1966 , that (I) we last saw the deceased alive on 20 Jan 1966 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we (did) (did not) view the body after death.									
23A. SIGNATURE Solomon Robbins M.D.						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 21 Jan 1966	
23C. PHYSICIAN'S NAME (Type) Solomon Robbins				23D. ADDRESS M.D. Sinai Hospital, Baltimore, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-23-66		24C. NAME OF CEMETERY or CREMATORY Balto. Hebrew Congregation		24D. LOCATION (City, town, or county) (State) Baltimore Maryland			
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1966		25B. NAME OF REGISTRAR Robert E. Robbins		25C. FUNERAL DIRECTOR Robert P. P. Singleton ADDRESS Singleton Funeral Home, Glen Burnie, Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

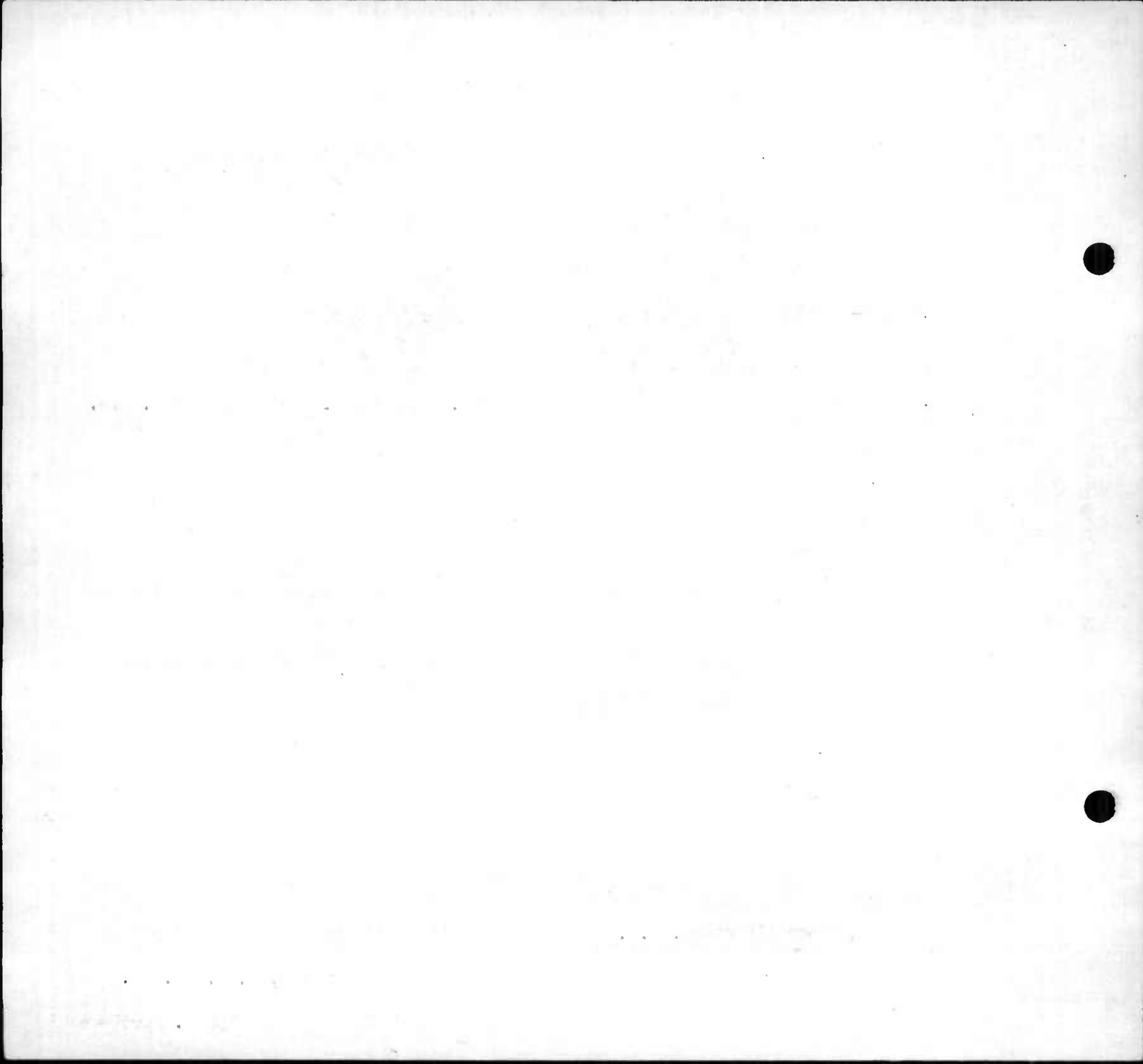
BIRTH NO. 66 00813		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00813	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) FINEGAN, THOMAS MILTON		2. DATE AND HOUR OF DEATH 1-20-66 1:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY ANNE ARUNDEL			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MONTEBELLO STATE HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) RURAL 02-00			
		D. STREET ADDRESS (If rural, give location) Rt 1 Box 166-A, Long Point, Pasadena			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 6-6-1891	9. AGE (In years last birthday) 74	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MEAT CUTTER		10B. KIND OF BUSINESS OR INDUSTRY Food Fair		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME Charles FINEGAN		14. MOTHER'S MAIDEN NAME WHITE		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-05-7790		17. INFORMANT Mrs Ruth Finegan (wife) ADDRESS SAME AS #4	
18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Broncho pneumonia DUE TO (B) Cerebral Thrombosis & RIGHT Hemiplegia DUE TO (C) Hypertensive and arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 2 Days 9 weeks Years	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (M) (this hospital) attended the deceased from JANUARY 13 1966 to JANUARY 20 1966 , that (I) (we) last saw the deceased alive on JANUARY 19 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas P. Connelly		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-20-66	
23C. PHYSICIAN'S NAME (Type) THOMAS P. CONNELLY		23D. ADDRESS M.D. MONTEBELLO STATE HOSPITAL.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/22/66		24C. NAME OF CEMETERY or CREMATORY Glen Haven Mem. Park	
24D. LOCATION (City, town, or county) (State) Glen Burnie, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 25 1966		25B. NAME OF REGISTRAR R. V. Singleton	
25C. FUNERAL DIRECTOR Glen Burnie, Md.		ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

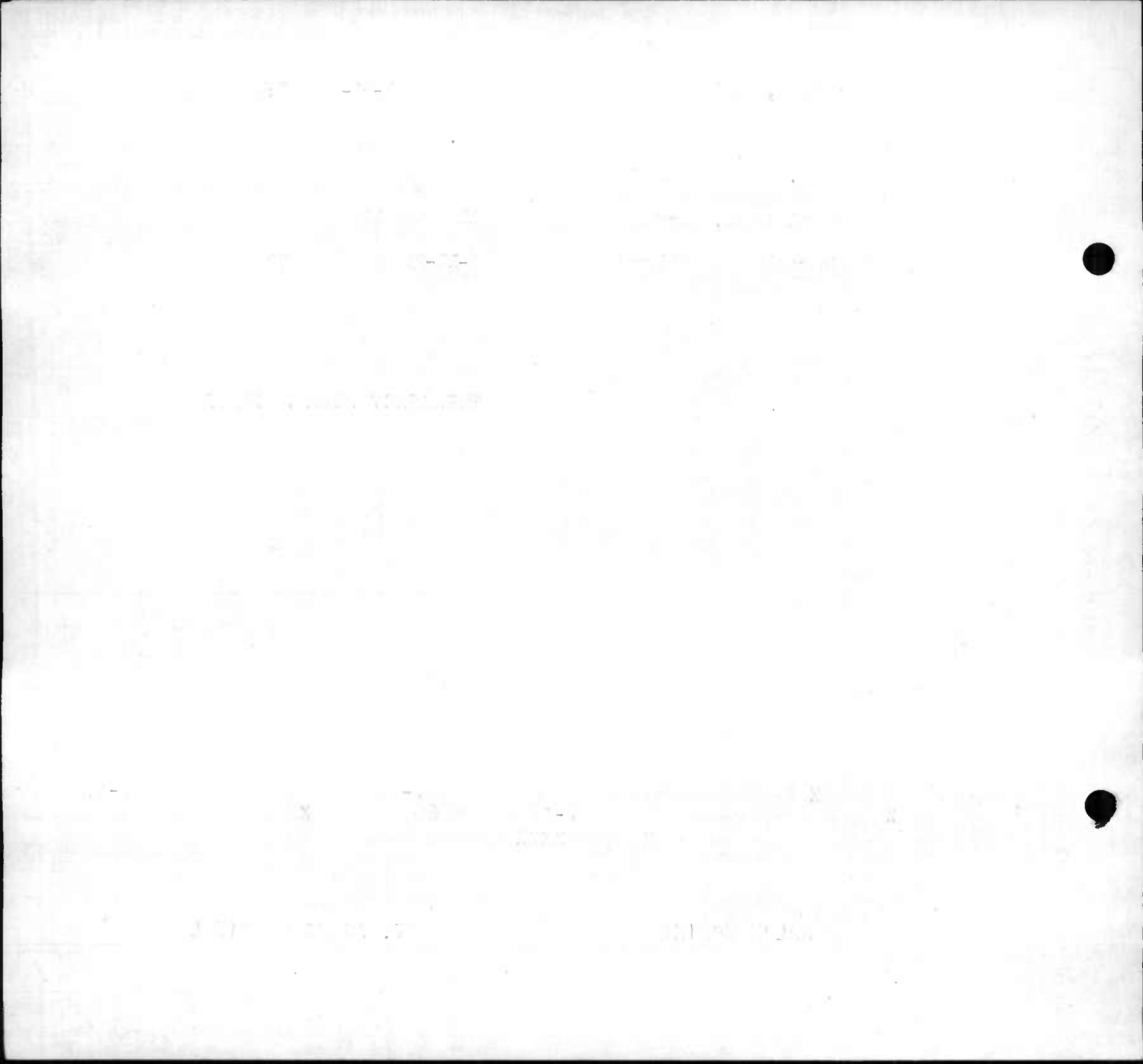
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00814	
CERTIFICATE OF DEATH					
BIRTH NO. 66 00814					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <i>Bernadette M. Barnett</i>		2. DATE AND HOUR OF DEATH <i>1-24-66 4:35 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General Hosp.</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore # 21225</i>			
		D. STREET ADDRESS (If rural, give location) <i>211 W-8th. Ave. 52-00</i>			
5. SEX <i>F</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>1-30-1893</i>	9. AGE (In years last birthday) <i>72</i>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sorter-Laundry</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>John Connelly</i>		14. MOTHER'S MAIDEN NAME <i>Catherine</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Mercedes R. Davis</i>	
				ADDRESS <i>211 8th. Ave.</i>	
18. <i>443X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>HASCD</i> DUE TO (B) <i>Cerebral hemorrhage 20</i> DUE TO <i># 1</i> (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that at (this hospital) attended the deceased from <i>1-23</i> 19 <i>66</i> to <i>1-24</i> 19 <i>66</i> , that the (we) last saw the deceased alive on <i>1-24</i> 19 <i>66</i> and that in our (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Verner Albertson, M.D.</i> M.D.				23B. DATE SIGNED <i>1-24-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Verner Albertson, M.D.</i> M.D.				23D. ADDRESS <i>South Baltimore General Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1 27, 66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Cross</i>	
24D. LOCATION (City, town, or county) (State) <i>Brooklyn, A. A. Co. Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 25 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Mc Gully</i>	
				ADDRESS <i>130 E. Fort Ave</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-6321		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00815	
BIRTH NO. 66 00815		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print)		1-22-66 3:15 PM 3:15 PM			
Braitsch, Paula		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		A. STATE Md. B. COUNTY A-A-Q			
FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
St. Agnes Hospital Wilkins & Caton Avenues Baltimore, Maryland		Pasadena			
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location)			
115 Magnolia Avenue		9. AGE (In years last birthday) 72			
5. SEX Female 6. RACE Caucasian 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		B. DATE OF BIRTH 6-11-93		11. BIRTHPLACE (State or foreign country) Md.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY home		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edmund Bryan		14. MOTHER'S MAIDEN NAME Anna Ambrose			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 422/1		EMERGENCY ROOM RECORDS			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Bilat. Bronchopneumonia		?	
ANTECEDENT CAUSES		(B) DUE TO A.S.C.U.D.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Cong. Heart Failure			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from 1-22-66 to 1-22-66, that (X) (we) last saw the deceased alive on 1-22-66 and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) (X) (X) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Ralph Updike				22 Jan 66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
RALPH UPDIKE				ST. AGNES HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1-27-66		London Park Cem.	
24D. LOCATION		24E. CITY, TOWN, or county		24F. STATE	
Baltimore		Baltimore		Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 25 1966		Robert E. Taylor		John J. Curran & Son Inc.	
25D. ADDRESS		25E. ADDRESS			
		Baltimore, Md.			



FUNERAL DIRECTOR: IMPORTANT

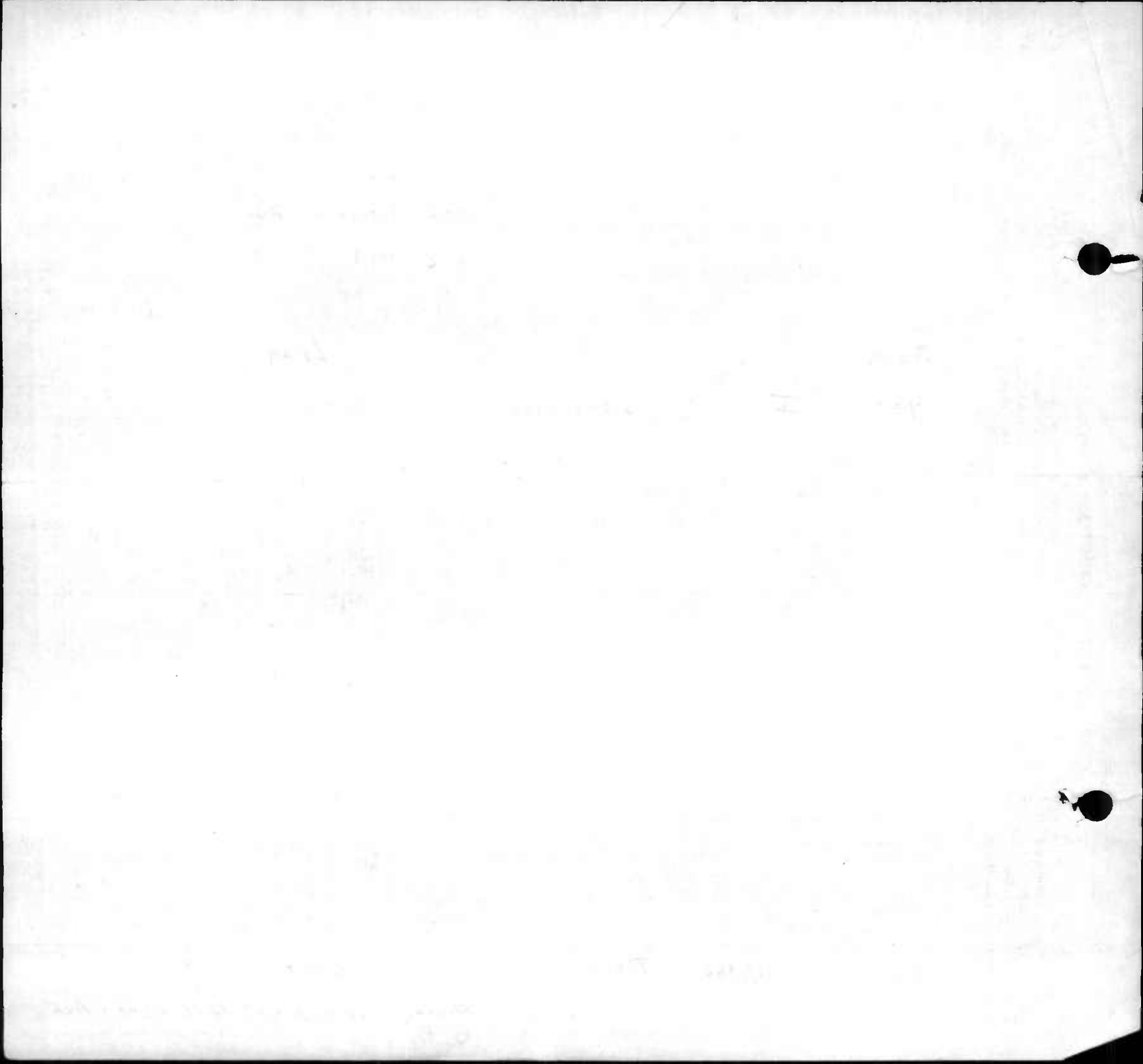
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00816	
BIRTH NO. 66 00816				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) EARL C. JOHNSON		2. DATE AND HOUR OF DEATH Jan. 22 1966 9:16 PM.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY 23-02		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION Franklin Square Hospital		D. STREET ADDRESS (If rural, give location) 7 E HENRIETTA ST.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Feb. 25, 1917	9. AGE (In years last birthday) 48	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lab. Tech.		10B. KIND OF BUSINESS OR INDUSTRY Extracts		11. BIRTHPLACE (State or foreign country) WEST VA.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Taylor Johnson		14. MOTHER'S MAIDEN NAME Bessie Hilkie	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Ronald C. Johnson	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 44681		CAUSE OF DEATH (A) CEREBRAL HEMORRHAGE DUE TO (B) HYPERTENSION - RENAL DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 3 days 1-1/2 years	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Wilfredo M. Mediano				23B. DATE SIGNED JAN. 22 1966	
23C. PHYSICIAN'S NAME (Type) WILFREDO M. MEDIANO				23D. ADDRESS FRANKLIN SQUARE HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1 26 1966		24C. NAME OF CEMETERY or CREMATORY Cedar Hill	
24D. LOCATION (City, town, or county) (State) Brooklyn, A. A. Co. Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 25 1966			
25B. NAME OF REGISTRAR Mc Gully		25C. FUNERAL DIRECTOR 130 E. Fort Ave			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00817	
BIRTH NO. 66 00817				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Cohen Jacob		2. DATE AND HOUR OF DEATH 1-24-66 10 ²⁰ A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSP OF BALTIMORE		D. STREET ADDRESS (If rural, give location) 2902 NORFOLK AVE			
5. SEX M	6. RACE W	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 1890-MAY 1	9. AGE (In years last birthday) 75	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY retired		11. BIRTHPLACE (State or foreign country) Russia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Chaim		14. MOTHER'S MAIDEN NAME LEAH	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes I		16. SOCIAL SECURITY NO. 218-32-2483		17. INFORMANT Harry M. Walen 5356 Carriage Ct. Balto. Md 21229	
18. 420.1 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO acute myocardial infarct immediate			
ANTECEDENT CAUSES		(B) DUE TO ASCVD		many years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED none		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) none		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/22/66 to 1-24-66 that (I) (we) lost saw the deceased alive on 1-24-66 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harry M. Walen				23B. DATE SIGNED 1-24-66	
23C. PHYSICIAN'S NAME (Type) Harry M. WALLEN		23D. ADDRESS M.D. 5356 Carriage Ct., Balto. Md			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/26/1966		24C. NAME OF CEMETERY or CREMATORY ROSEDALE	
24D. LOCATION BALTO. MD		24E. NAME OF REGISTRAR Rosa E. Johnson		24F. FUNERAL DIRECTOR SYLVAN S. LEWIS + Son - 3319 Olympia Ave	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1966		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00818	
BIRTH NO. 66 00818		M.E. CASE NO. 66 00818		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Becker, Frieda		2. DATE AND HOUR OF DEATH Jan 23, 1966 9:15 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital of Baltimore		A. STATE Md B. COUNTY Balt			
5. SEX F 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 7-6-93		9. AGE (In years last birthday) 72	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Russia	
13. FATHER'S NAME ABRAHAM		14. MOTHER'S MAIDEN NAME SPRAY		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hosp. Chart	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Acute Myocardial Infarction DUE TO (B) Arteriosclerotic Heart Disease DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH several hours	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from Jan. 23, 1966 to Jan. 23, 1966, that (we) last saw the deceased alive on Jan. 23, 1966 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Louis Krause				23B. DATE SIGNED Jan. 23, 1966	
23C. PHYSICIAN'S NAME (Type) Louis Krause				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/24/1966		24C. NAME OF CEMETERY or CREMATORY ROSEDALE	
24D. LOCATION BALTO		24E. LOCATION MD		24F. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1966		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR SYLVESTER S. LEWIS & SON - 3519 OLNEY AVE	

W. B. R. A. M.

W. B. R. A. M.

W. B. R. A. M.

W. B. R. A. M.

W. B. R. A. M.

W. B. R. A. M.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH										Registered No. 66 00819	
BIRTH NO. 66 00819											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) GEORGE W. YOX				2. DATE AND HOUR OF DEATH 1-21-66 9:10 A.M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township) CATONSVILLE 5300							
				D. STREET ADDRESS (If rural, give location) 28 N. SYMINGTON AVE.							
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH MAY 9, 1906	9. AGE (In years last birthday) 59	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WELDER			10B. KIND OF BUSINESS OR INDUSTRY KOPPERS CO.			11. BIRTHPLACE (State or foreign country) MD.			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME GEORGE W. YOX						14. MOTHER'S MAIDEN NAME MARY A. MURRAY					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 213-1-1366			17. INFORMANT Mr. George A. Yox, 28 N. Symington Ave			ADDRESS		
18. 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral Infarction				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO Massive Cerebrovascular Hemorrhage							
				(B) DUE TO Atherosclerotic cerebrovascular disease							
				(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) YES			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED White At <input type="checkbox"/> Work Not White At <input type="checkbox"/> Work			21F. HOW DID INJURY OCCUR?					
22. I certify that (this hospital) attended the deceased from JAN-18-1966 to JAN 21 1966, that (we) last saw the deceased alive on 1-21-1966 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.											
23A. SIGNATURE Joseph Notarangelo M.D.						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 1-21-1966		
23C. PHYSICIAN'S NAME (Type) JOSEPH NOTARANGELO M.D.						23D. ADDRESS MERCY HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 1-24-66			24C. NAME OF CEMETERY OR CREMATORY Lakewood Cemetery			24D. LOCATION (City, town, or county) (State) Carroll Co., Md.		
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1966			25B. NAME OF REGISTRAR R. E. Stachura			25C. FUNERAL DIRECTOR John C. ...			ADDRESS		

1911

222

1911

1911

66 00820

BALTIMORE CITY HEALTH DEPARTMENT

66 00820

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES MASON BROOKS

2. DATE AND HOUR PRONOUNCED DEAD

January 20, 1966 12:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OF LOCATION)
HOSPITAL OR INSTITUTION

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland Harford

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Joppa

D. STREET ADDRESS (If rural, give location)

1814 Hanson Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Never Married

8. DATE OF BIRTH

Dec. 27, 1942

9. AGE (In years
last birthday)

23

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Draftsman

10B. KIND OF BUSINESS OR INDUSTRY

Public Service

11. BIRTHPLACE (State or foreign country)

Ohio

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Lester Howard Brooks

14. MOTHER'S MAIDEN NAME

Edith May Koerber

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.
213-42-369317. INFORMANT ADDRESS
Mrs. Edith M. Brooks, 1814 Hanson Road, Joppa, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Congenital Heart Disease (Interventricular
Septal Defect).

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/21/66

23A. BURIAL CREMATION,
REMOVAL (Specify)
Removal

23B. DATE

Jan. 22, 1966

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

East Liverpool, Ohio

24A. DATE REC'D BY HEALTH DEPT.

JAN 25 1966

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Howard K. McComas & Son, Abingdon, Md.

ADDRESS

letter from funeral director. 1-28-66 cpb

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 00821					CERTIFICATE OF DEATH			Registered No. 66 00821	
1. NAME OF DECEASED (Type or Print) Catherine Lawson					2. DATE AND HOUR OF DEATH Jan - 19, 1966 2:500 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 University Hospital					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 16-07 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2936 West Mosher St. 21216				
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH 7/23/03	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME - ?					14. MOTHER'S MAIDEN NAME - ?				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. ?		17. INFORMANT Medical record			ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) 15981 Suspended aortic aneurysm GI tract					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH 8 years	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2 None			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (1) (this hospital) attended the deceased from Jan. 16, 1966 to Jan. 19, 1966 , that (1) (we) last saw the deceased alive on Jan. 19, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Richard D. Bogg					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 19 Jan 66	
23C. PHYSICIAN'S NAME (Type) RICHARD D. BOGG JR.					23D. ADDRESS UNIVERSITY HOSP BALTO.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 1/24/66		24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md		
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1966			25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Adolphus Halstead 1206 W. North Ave				

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

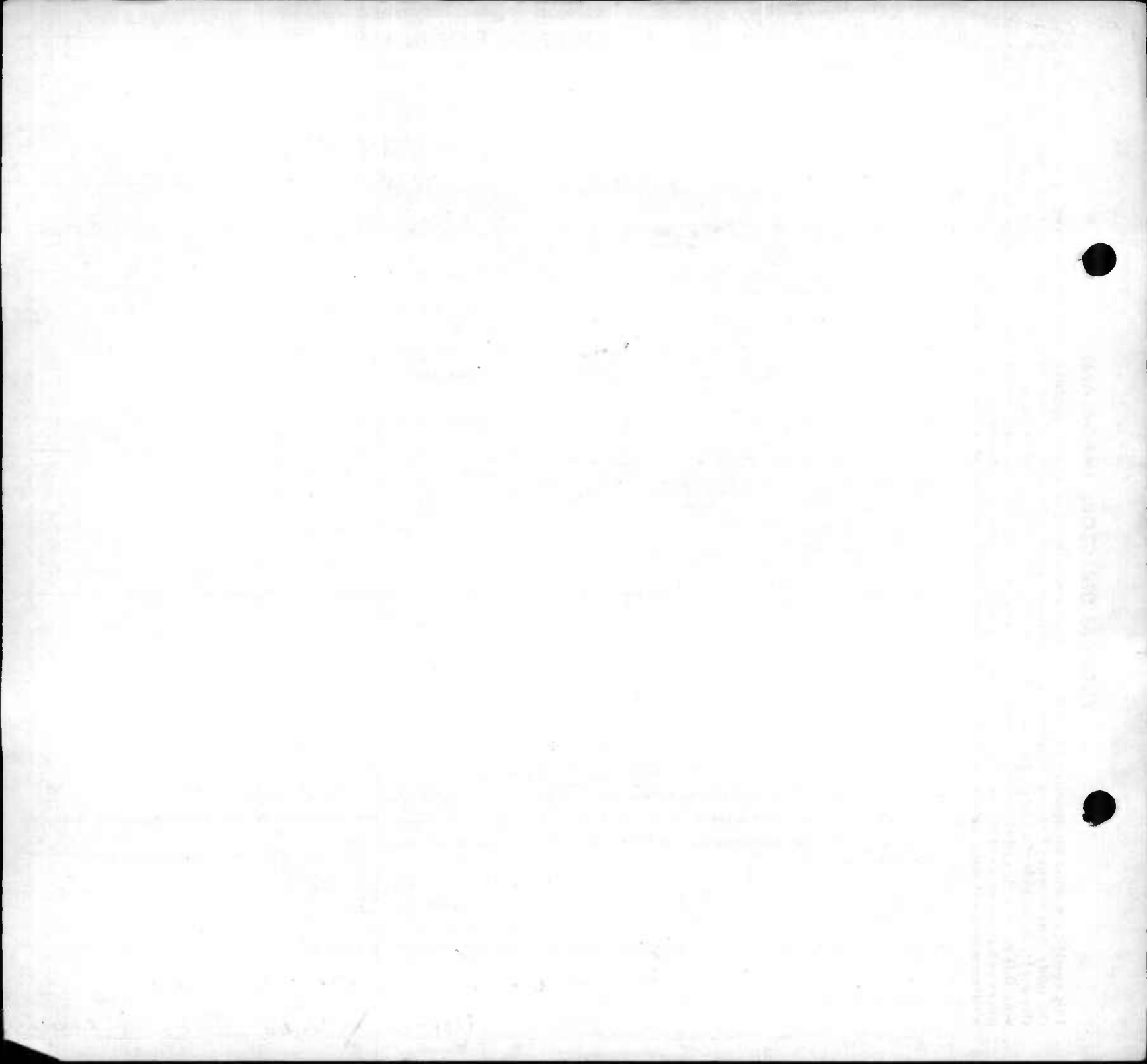
BIRTH NO. 66 00822		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00822	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HOGAN, JAMES ALOSUS		2. DATE AND HOUR OF DEATH 1-23-66 12:45 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Maryland 12-01			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 3700 N. Charles St.			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 2-23-82	9. AGE (In years last birthday) 83	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Food Broker		10B. KIND OF BUSINESS OR INDUSTRY Self employed		11. BIRTHPLACE (State or foreign country) Scranton, Pennsylvania	
13. FATHER'S NAME PATRICK HOGAN		14. MOTHER'S MAIDEN NAME CATHERINE		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-24-1170		17. INFORMANT Mrs. Elsie Hogan WIFE 3700 N. Charles St.	
18. 002.11		CAUSE OF DEATH		ADDRESS 3700 N. Charles St.	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) SEPTICEMIA		(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. PULMONARY TUBERCULOSIS PSP.		(B) DUE TO			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-7-66 to 1-23-66, that (I) (we) last saw the deceased alive on 1-23-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE B. Gross		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1-23-66	
23C. PHYSICIAN'S NAME (Type) BRIAN H. GROSS,		23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/26/1966		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery	
24D. LOCATION (City, town, or county) (State) Pikesville, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 25 1966		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR TICKNERS		ADDRESS BALTIMORE, Md. 17			

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

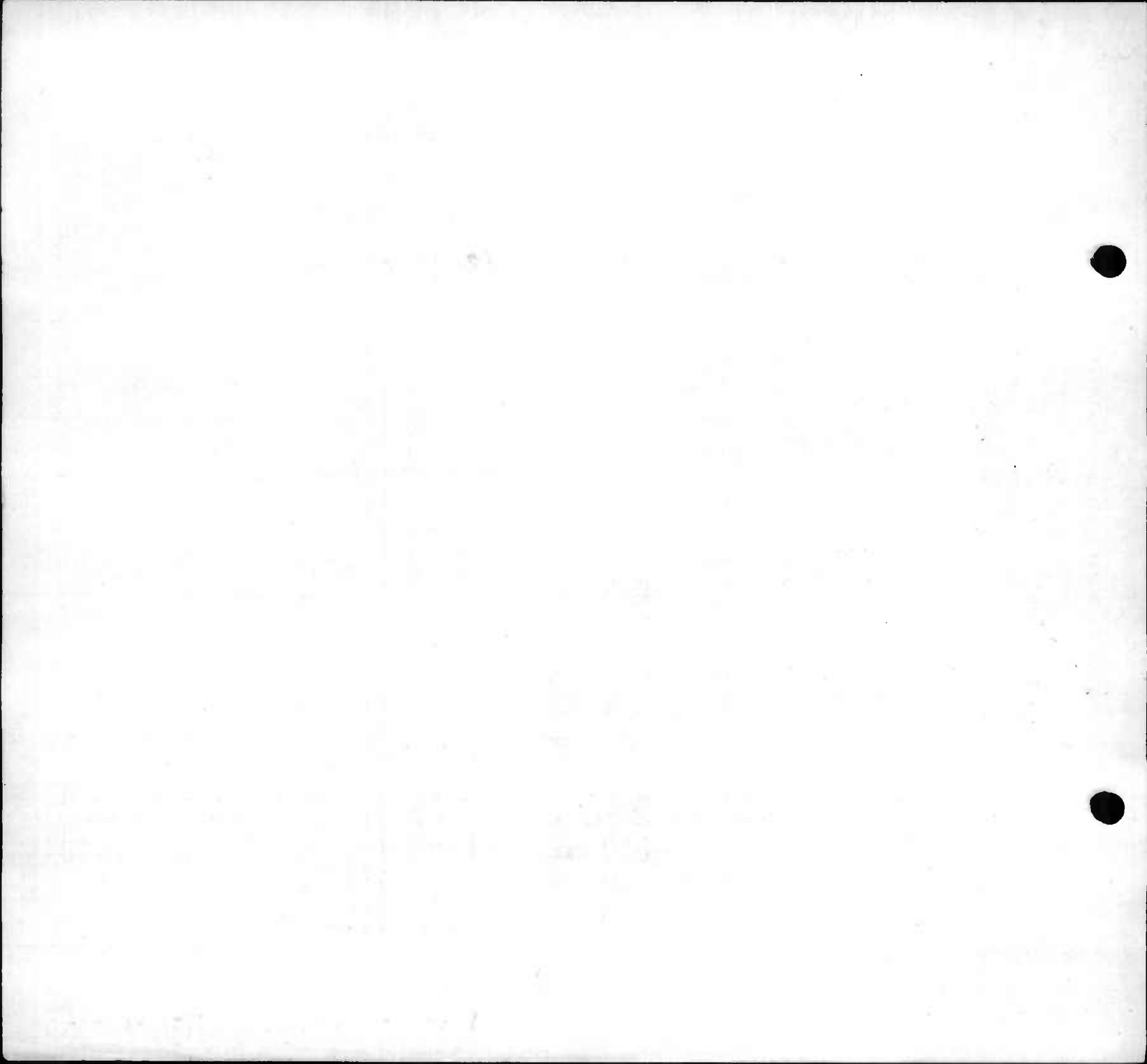
BIRTH NO. 66-00823		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 347456	
M.E. CASE NO.		CERTIFICATE OF DEATH		66-00823	
1. NAME OF DECEASED (Type or Print) COLE, Michelle		2. DATE AND HOUR OF DEATH 1/22/66 8:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital		A. STATE MARYLAND B. COUNTY 27-18			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN Baltimore			
		D. STREET ADDRESS (If rural, give location) 4803 Beaufort Ave.			
5. SEX ♀	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) never married	8. DATE OF BIRTH 12/7/65	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alvin Cole		14. MOTHER'S MAIDEN NAME Deborah			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Pneumonia		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CHIEF OF POST-MORTEM EXAMINER 4/17/66			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 1/22 1966 to 1/22 1966, that (1) (we) last saw the deceased alive on never 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sanford Levin		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/22/66	
23C. PHYSICIAN'S NAME (Type) SANFORD LEVIN		23D. ADDRESS Sinai Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-25-66		24C. NAME of CEMETERY or CREMATORY MT. Auburn	
		24D. LOCATION BALTO. Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1966		25B. NAME OF REGISTRAR MORTON & Dyett		25C. FUNERAL DIRECTOR F. H. 1701 LAUREN	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00824		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00824	
M.E. CASE NO. B		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Barbara McGill Pack		2. DATE AND HOUR OF DEATH 1.23.66 12.30 a.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hosp.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 16-07 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3116 Baker St.			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 12.16.42	9. AGE (In years last birthday) 23 yr.	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Earnest Pack		14. MOTHER'S MAIDEN NAME Ruth Johnson		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mother ADDRESS 2309 Laurette Ave	
18. 79531 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Subacute hemorrhage DUE TO		(B) DUE TO	
(C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1.16 19 66 to 1.23 19 66 , that (I) (we) last saw the deceased alive on 1.23 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE F. Abbousy M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 1.23.66	
23C. PHYSICIAN'S NAME (Type) Fadhil Abbousy		23D. ADDRESS Lutheran Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-26-66		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Pk.	
24D. LOCATION (City, town, or county) Arbutus Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 25 1966			
25B. NAME OF REGISTRAR R. B. E. [unclear]		25C. FUNERAL DIRECTOR MORTON + DYER		25D. ADDRESS 1701 Laurens	



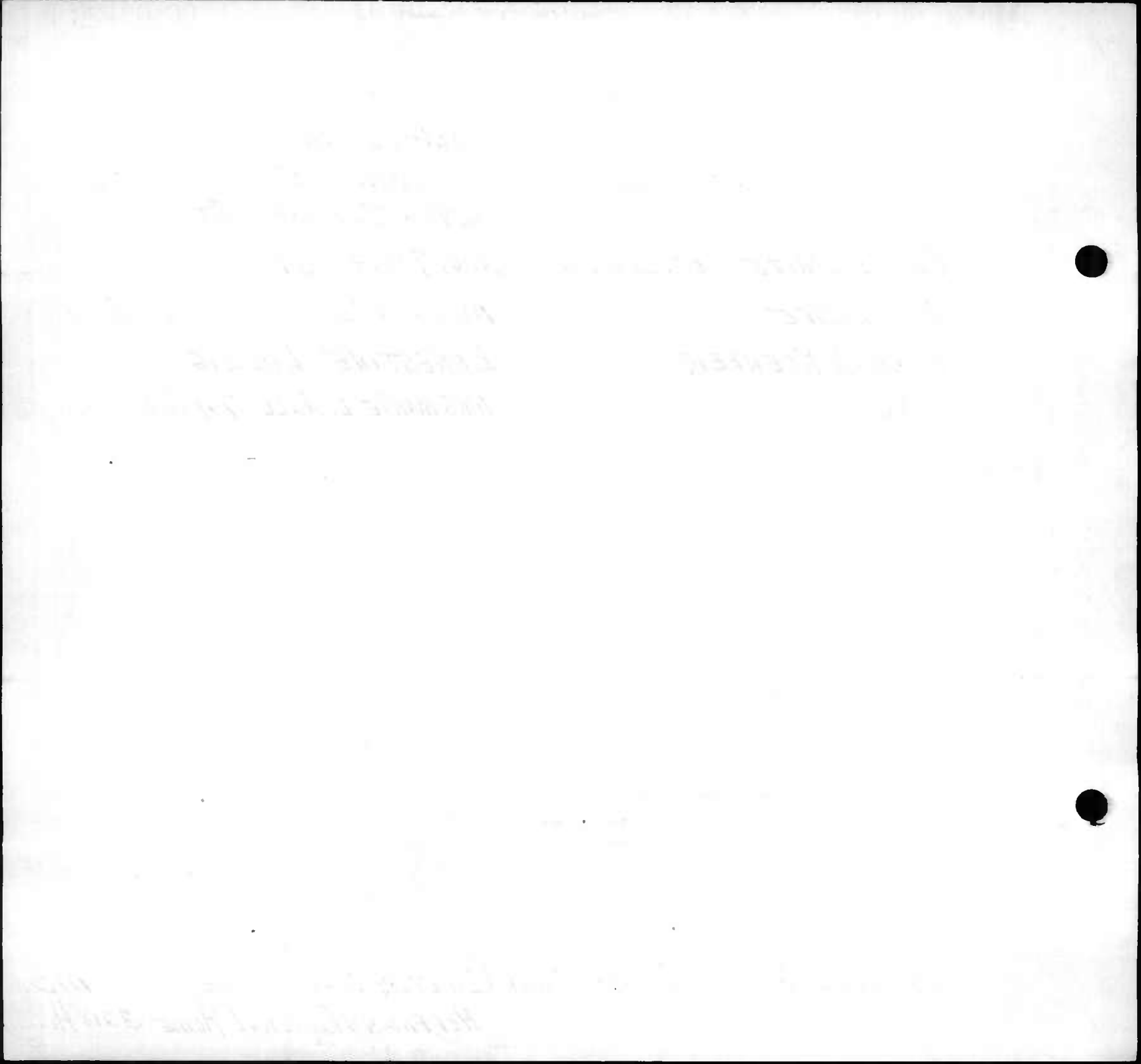
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 66 00825	
BIRTH NO. 66 00825		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Charles Young		2. DATE AND HOUR OF DEATH 1-20-66 6:20 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 7-01			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LThe Johns Hopkins Hospital				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 3118 McElderry Street			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Mafried	8. DATE OF BIRTH 9-16-85	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY RAILWAY EXPRESS MARYLAND		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clark Young				14. MOTHER'S MAIDEN NAME Virginia Fogle			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 74-03-4090		17. INFORMANT MR. HERBERT YOUNG		ADDRESS 3118 MCELDERRY ST	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Anemia, iron deficient, severe 6 years DUE TO (B) Probable intermittent gi bleeding 6 years DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 18, 1966 to Jan 20, 1966, that (I) (we) last saw the deceased alive on Jan 20, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE W Leigh Thompson				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/> Interne Jan 20, 1966		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) WL Thompson				23D. ADDRESS M.D. Osler; Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/24/66		24C. NAME OF CEMETERY or CREMATORY MORELAND MEMORIAL PARK		24D. LOCATION (City, town, or county) BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1966		25B. NAME OF REGISTRAR Robert E. Jefferson		25C. FUNERAL DIRECTOR HOFFMANN FUNERAL HOME		ADDRESS 3218 HUDSON ST.	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

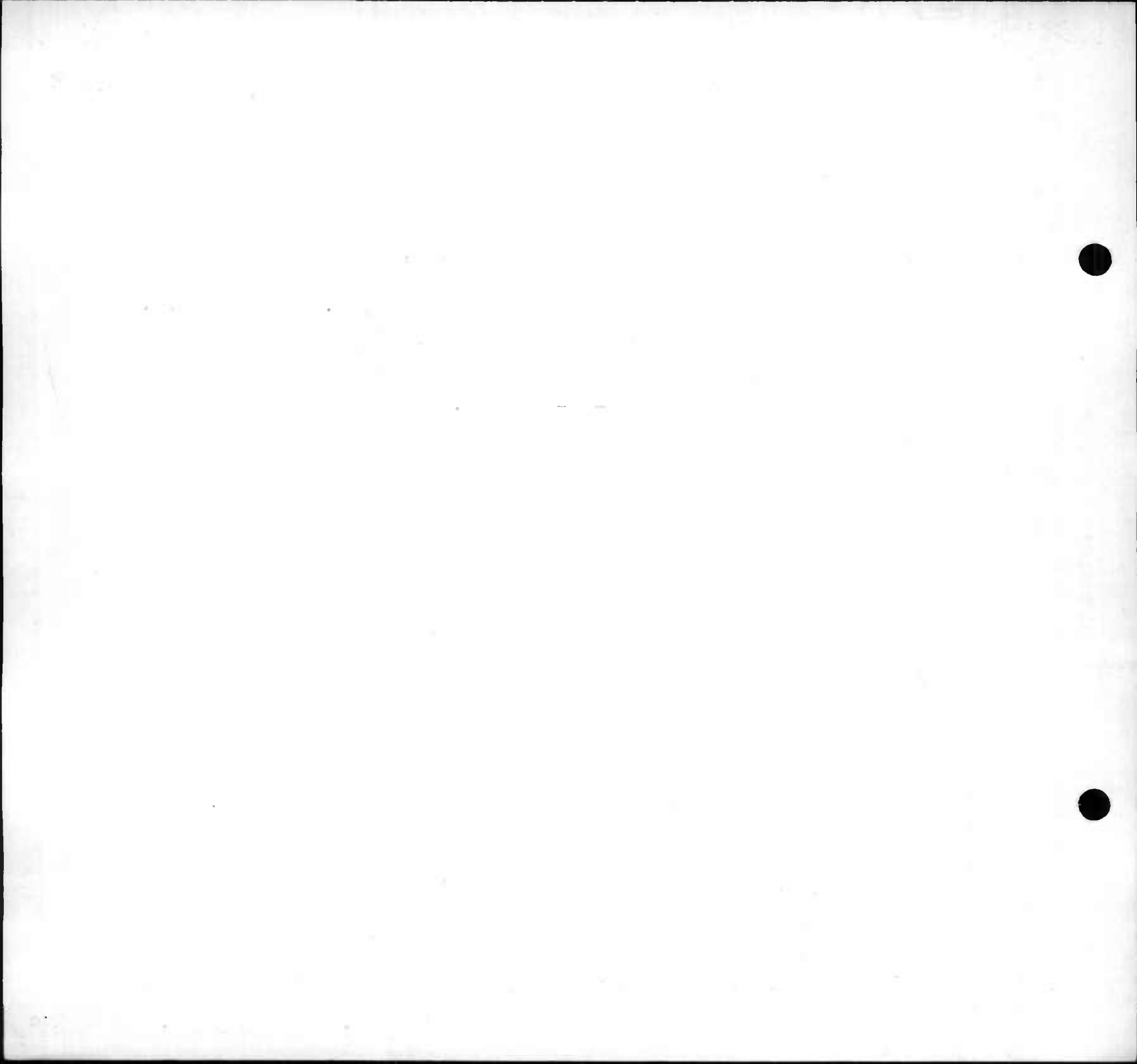
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <u>66 00826</u>				
BIRTH NO. <u>66 00826</u>									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <u>IDA A. HORNER</u>					2. DATE AND HOUR OF DEATH <u>JAN. 19, 1966</u> <u>5:45 P.</u> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>741 S. POTOMAC ST.</u>					A. STATE <u>MARYLAND</u>				
					B. COUNTY <u>1-02</u>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>				
					D. STREET ADDRESS (If rural, give location) <u>2906 E. PRATT ST.</u>				
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>AUG. 7 1884</u>	9. AGE (In years last birthday) <u>81</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>HERMAN KOEHLER</u>					14. MOTHER'S MAIDEN NAME <u>ERNESTINE LUDWIG</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. MARIE L. AULL</u>			ADDRESS <u>741 S. POTOMAC ST.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic Cardio-vascular Disease</u>					INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs.</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>June</u> 19 <u>58</u> to <u>Jan. 18</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Jan. 18</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Clarence W. LeDoux</u> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <u>1/21/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Clarence W. LeDoux</u> M.D.					23D. ADDRESS <u>3023 Eastern Ave.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-22-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>LONDON PARK CEMETERY</u>			24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1966</u>		25B. NAME OF REGISTRAR <u>CLARENCE W. LE DOUX</u>			25C. FUNERAL DIRECTOR <u>HOFFMAN FUNERAL HOME</u>			ADDRESS <u>3218 HUDSON ST.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00827		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 00827	
1. NAME OF DECEASED (Type or Print) Ada News			2. DATE AND HOUR OF DEATH January 21, 1966 9:40 P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2027 Wheeler Ave			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 15-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2027 Wheeler Ave		
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH June 4, 1899	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY Private Family		11. BIRTHPLACE (State or foreign country) Ableville, S.C	
12. CITIZEN OF WHAT COUNTRY? U.S.A			13. FATHER'S NAME William Dixon		
14. MOTHER'S MAIDEN NAME Minnie ?			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 214-24-4903			17. INFORMANT Mr. Eugene News 2027 Wheeler Ave		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 172 x 41 260 x Ascarosarcoma of the Uterus = Metastasis			INTERVAL BETWEEN ONSET AND DEATH 1 yr		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II Diabetes Mellitus			16 yrs.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec. 13, 1965 to Jan. 21, 1966 , that (I) last saw the deceased alive on Jan. 8, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Roland T. Smoot				23B. DATE SIGNED 1/24/66	
23C. PHYSICIAN'S NAME (Type) ROLAND T. SMOOT				23D. ADDRESS 3817 Copely Rd, Balto. 15, Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/25/66		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park	
24D. LOCATION Arbutus Balto Co., Md		25A. DATE REC'D BY HEALTH DEPT. JAN 25 1966			
25B. NAME OF REGISTRAR Herbert E. Nutter		25C. FUNERAL DIRECTOR Herbert E. Nutter 3035 W. North Ave			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V-536 1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 66 00828

BIRTH NO. 66 00828

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

ANNA Venture

2. DATE AND HOUR OF DEATH

1. 23. 66 12. 20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

46 Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

1802

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

415 N. Barbary Carey St.

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

4-22-1900

9. AGE (In years last birthday)

65

10. Under 1 Yr.

Months: Days

11. Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Charlottesville Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Allen Watson

14. MOTHER'S MAIDEN NAME

Annie

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Gerald Venture-3401 Duvall Ave.

18. 260 X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Diabetes

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO

hypertension

(C) DUE TO

anemia

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from DEC 9 1965 to JAN 23 1966, that (we) lost saw the deceased alive on JAN 23 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

F. Abbassy

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1. 23. 66

23C. PHYSICIAN'S NAME (Type)

Fachil Abbassy

M.D.

23D. ADDRESS

Lutheran Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1/26/66

24C. NAME of CEMETERY or CREMATORY

Family Lot

24D. LOCATION

(City, town, or county)

(State)

Charlottesville Va.

25A. DATE REC'D BY HEALTH DEPT.

JAN 25 1966

25B. NAME OF REGISTRAR

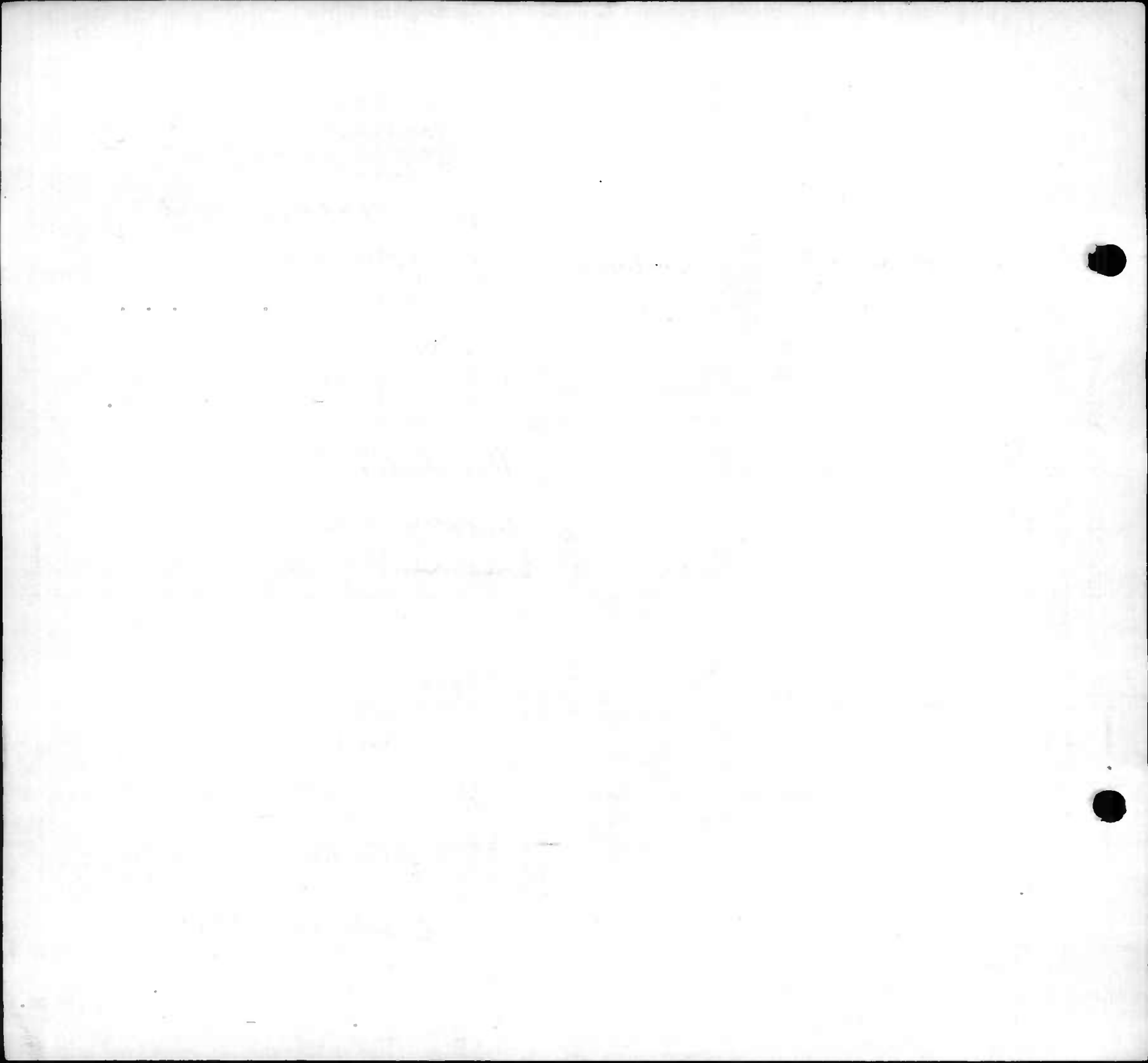
Robert E. J. J.

25C. FUNERAL DIRECTOR

Herbert E. J.

ADDRESS

Nutter-3035 W. North Ave.



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BALTIMORE CITY HEALTH DEPARTMENT				MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 00829			
BIRTH NO. 66 00829				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) Genevieve W. Langhorn				2. DATE AND HOUR PRONOUNCED DEAD 1/22/66 1:00 p/ M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Lutheran Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-48			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 2111 Garrison Blvd.			
5. SEX female	6. RACE colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH June 25, 1904	9. AGE (in years last birthday) 61	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY Pvt. Family		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Williams				14. MOTHER'S MAIDEN NAME Bessie Herbert			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-10-5904	17. INFORMANT ADDRESS Edward Langhorn - 2111 Garrison Blvd.				
18. CAUSE OF DEATH 443 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic and hypertensive cardiovascular disease DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 1/23/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1/23/66							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 1-26-66	23C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		23D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
24A. DATE REC'D BY HEALTH DEPT. JAN 25 1966		24B. NAME OF REGISTRAR Charles R. Law		24C. FUNERAL DIRECTOR ADDRESS 802 Madison Ave.			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00830	
BIRTH NO. 66 00830				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Brown, William A.			2. DATE AND HOUR OF DEATH 1-22-66 1:45 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 LUTHERAN Hosp. of Md.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Baltimore B. COUNTY Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) 500 DOLPHIN ST. D. STREET ADDRESS (If rural, give location)		
5. SEX M	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10-21-07	9. AGE (In years last birthday) 58	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Superintendent -			11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Brown, Sr.			14. MOTHER'S MAIDEN NAME Ella Brown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 255-24-4385		17. INFORMANT Patience's chart -
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 420.1 I Cardiac Arrest - Coronary Heart Disease.			INTERVAL BETWEEN ONSET AND DEATH 45 min.		
<p style="text-align: center;">II</p> <p>19A. DATE OF OPERATION 3-1-7-65 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Proctitis</p> <p>20A. AUTOPSY (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?</p>					
22. I certify that (I) (this hospital) attended the deceased from Jan. 6 19 66 to Jan. 22 19 66 , that (I) (we) last saw the deceased alive on Jan. 22 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. Mamarik, Sr.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) A. MAMARIK, SR.				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-25-66		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 25 1966			
25B. NAME OF REGISTRAR Charles R. Law		25C. FUNERAL DIRECTOR ADDRESS 802 Madison Ave.			

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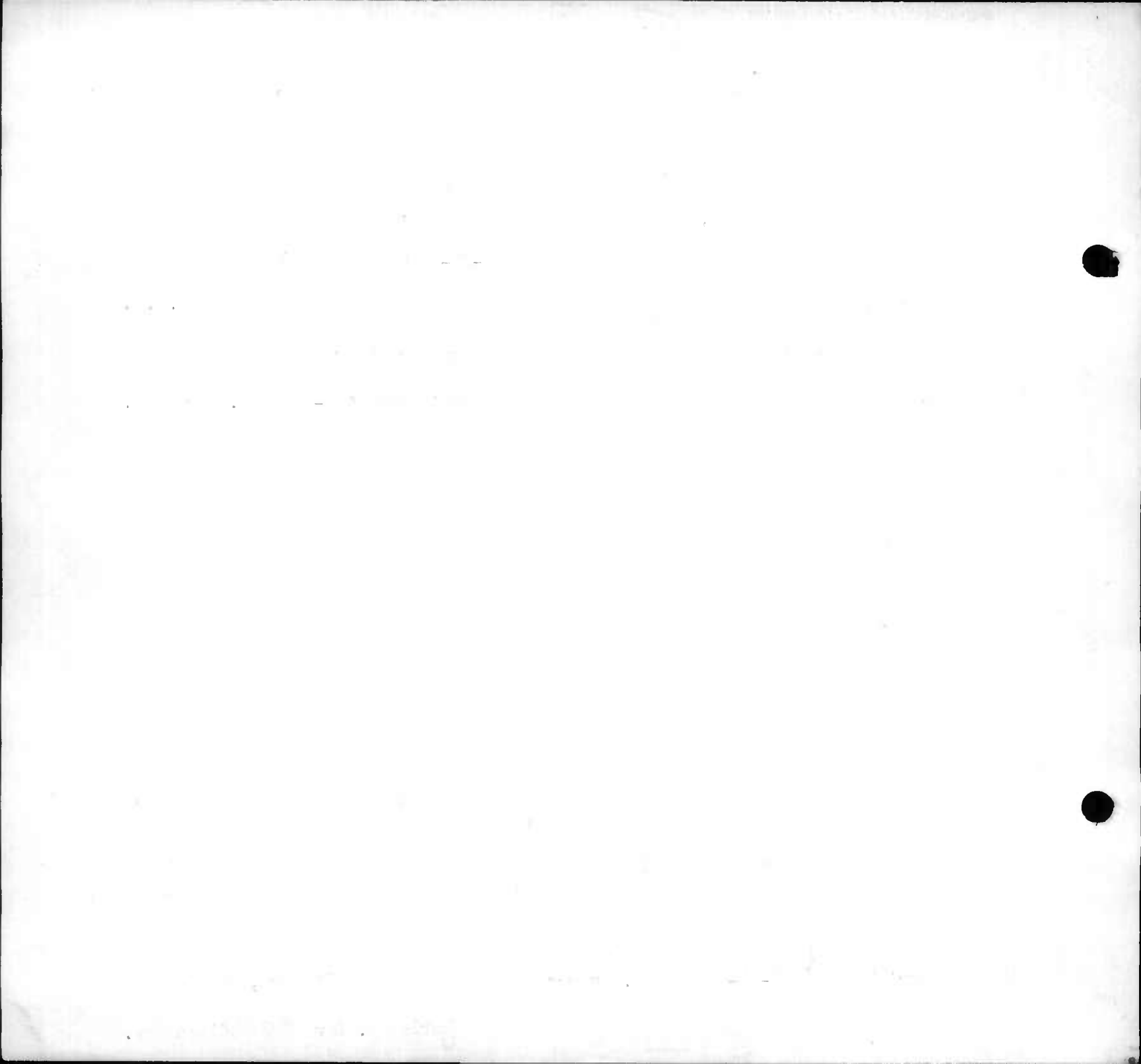
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 00831</u>	
BIRTH NO. <u>66 00831</u>		CERTIFICATE OF DEATH			
M.E. CASE NO. <u>W.</u>		2. DATE AND HOUR OF DEATH <u>January 22, 1966</u> <u>9:05 A.M.</u>			
1. NAME OF DECEASED (Type or Print) <u>Ernest Hackett</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>15-01</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1722 N. Carey Street</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>2-22-1889</u>	9. AGE (In years last birthday) <u>76</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waiter</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Jerome Hackett</u>		14. MOTHER'S MAIDEN NAME <u>Amy Carpenter</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Coddie Hackett - 1722 N. Carey St.</u>	
18. <u>443X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <u>C V A.</u> DUE TO (B) <u>Hypertension and</u> DUE TO (C) <u>arteriosclerotic cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>January 17, 1966</u> to <u>January 22, 1966</u> , that (I) (we) last saw the deceased alive on <u>January 22, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED <u>January 22, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>A. RIGGS</u>				23D. ADDRESS M.D. <u>1514 Division Street</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-27-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1966</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Charles R. Law 802 Madison Ave.</u>			



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66 00832

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 00832

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CURTIS WYATT

2. DATE AND HOUR PRONOUNCED DEAD

1-23-66

11:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

LUTHERAN HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1927 W. Mosher Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

9-22-1912

9. AGE (In years last birthday)

53

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

City Employee

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Thomas Wyatt

14. MOTHER'S MAIDEN NAME

Rebecca Walker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

George Wyatt

ADDRESS

Same

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Gunshot wound of chest

(A) DUE TO

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

2nd floor front bedroom, 1927 W. Mosher Street

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) 1 23 '66

App. 10:00 PM

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot self in chest

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 1-24-66

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

1-27-66

23C. NAME OF CEMETERY or CREMATORY

Carver Court

23D. LOCATION (City, town, or county)

Lanham

(State)

md

24A. DATE REC'D BY HEALTH DEPT.

JAN 25 1966

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Chas. Wilson 1000 Bunting Ave

ADDRESS

VALLEY FORCE

RAIDED

9-22-12
J. J. [unclear]
[unclear]
[unclear]

10-1-12

10-1-12
[unclear]
[unclear]

1-1-13
[unclear]
[unclear]

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BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES

SCOTT

2. DATE AND HOUR PRONOUNCED DEAD

January 20, 1966

2:35 P

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Bon Secour Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2245 W. Fayette Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Child

8. DATE OF BIRTH

Dec 30 1958

9. AGE (In years
last birthday)

7

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Junior

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Thomas H Scott

14. MOTHER'S MAIDEN NAME

Beatrice Scott

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Mr Beatrice Scott

ADDRESS

Same

18.

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CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Craniocerebral Injury.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Fayette St., W. of Bentalou St. 20-02

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
1 19 '66 P

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Pedestrian struck by auto.

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/21/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1-24-66

23C. NAME OF CEMETERY or CREMATORY

Baltimore

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

JAN 25 1966

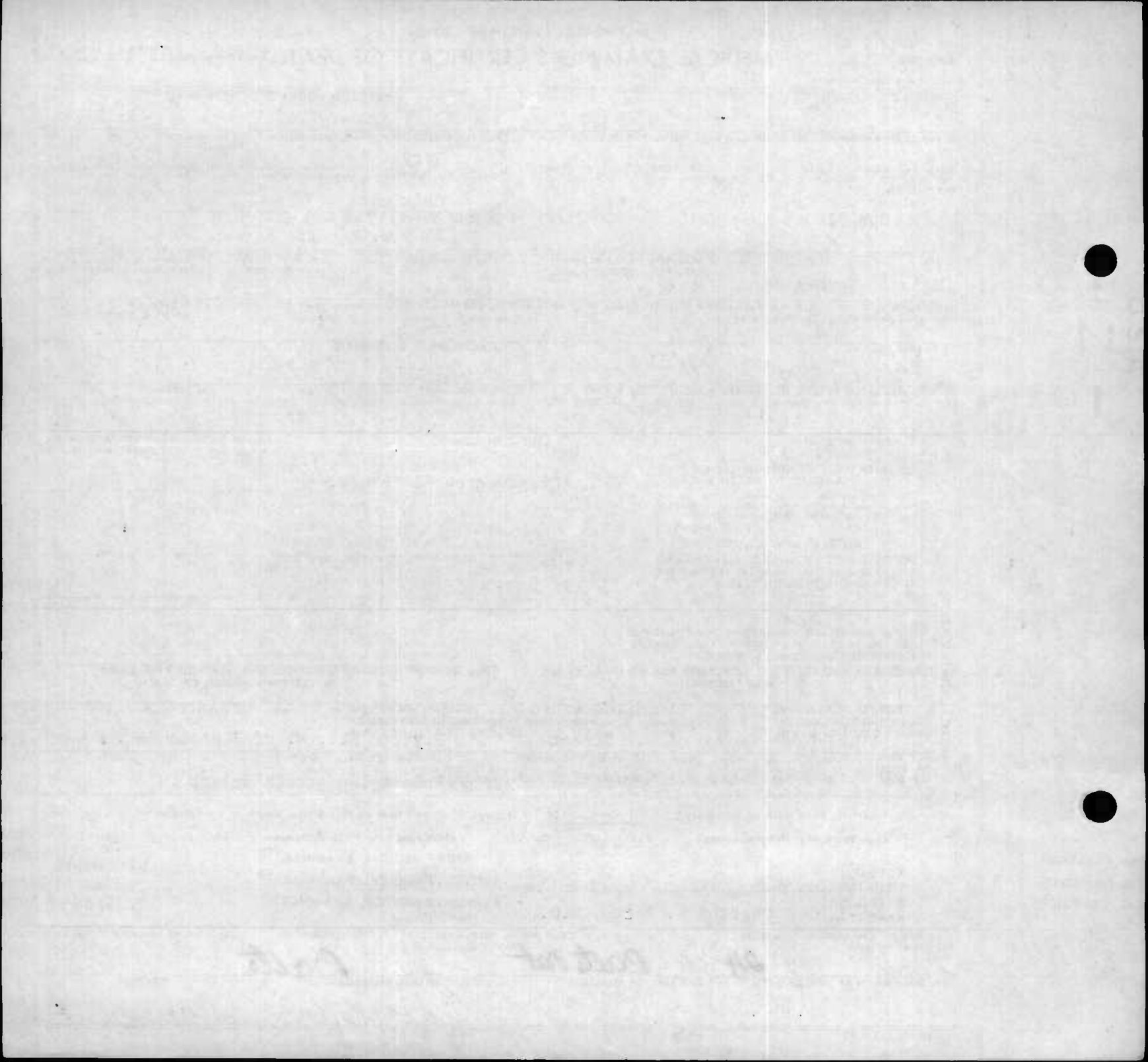
24B. NAME OF REGISTRAR

R. B. 2. Taylor, M.D.

24C. FUNERAL DIRECTOR

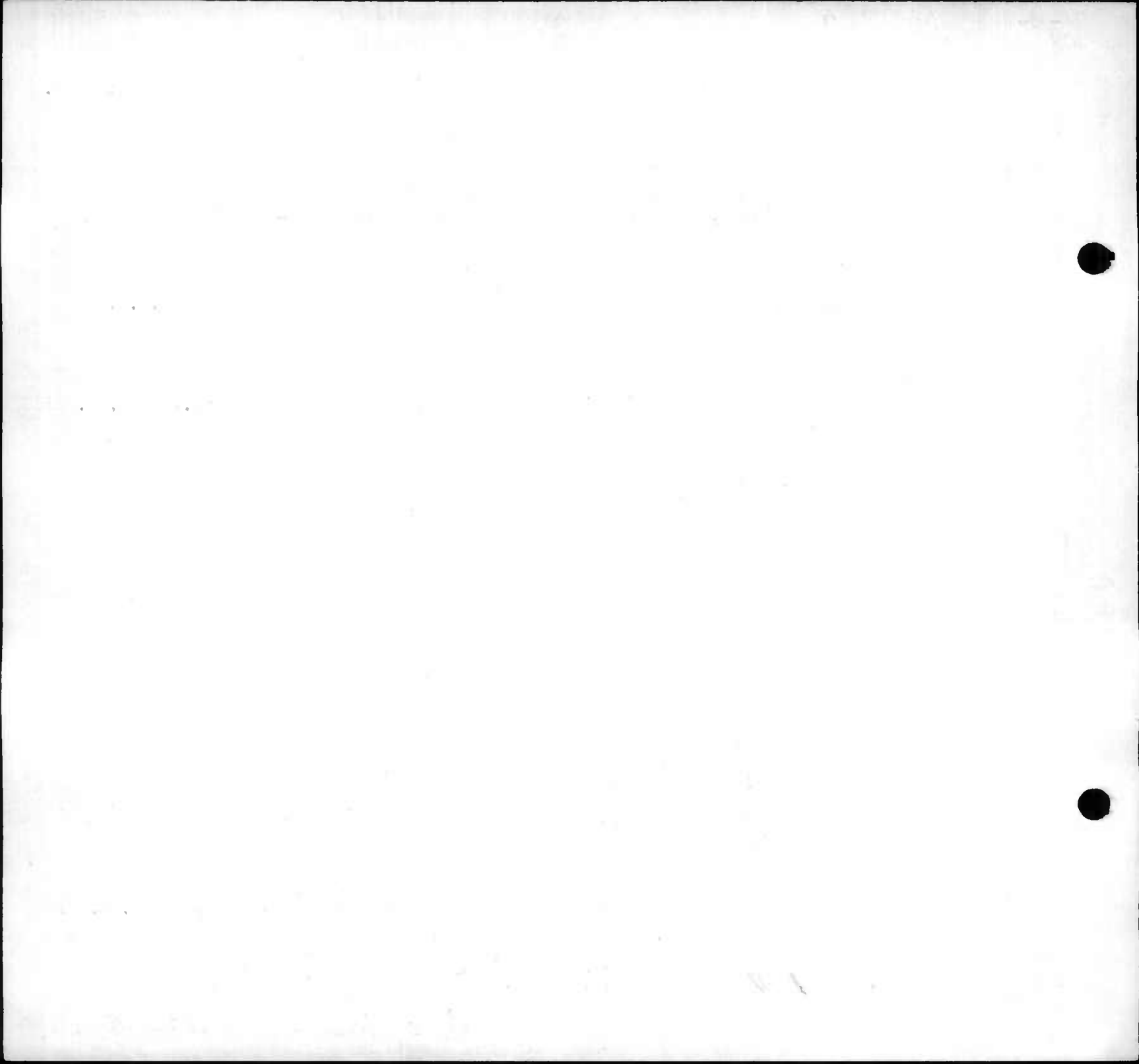
Choy O. Wilson - 1000 Broadway

ADDRESS



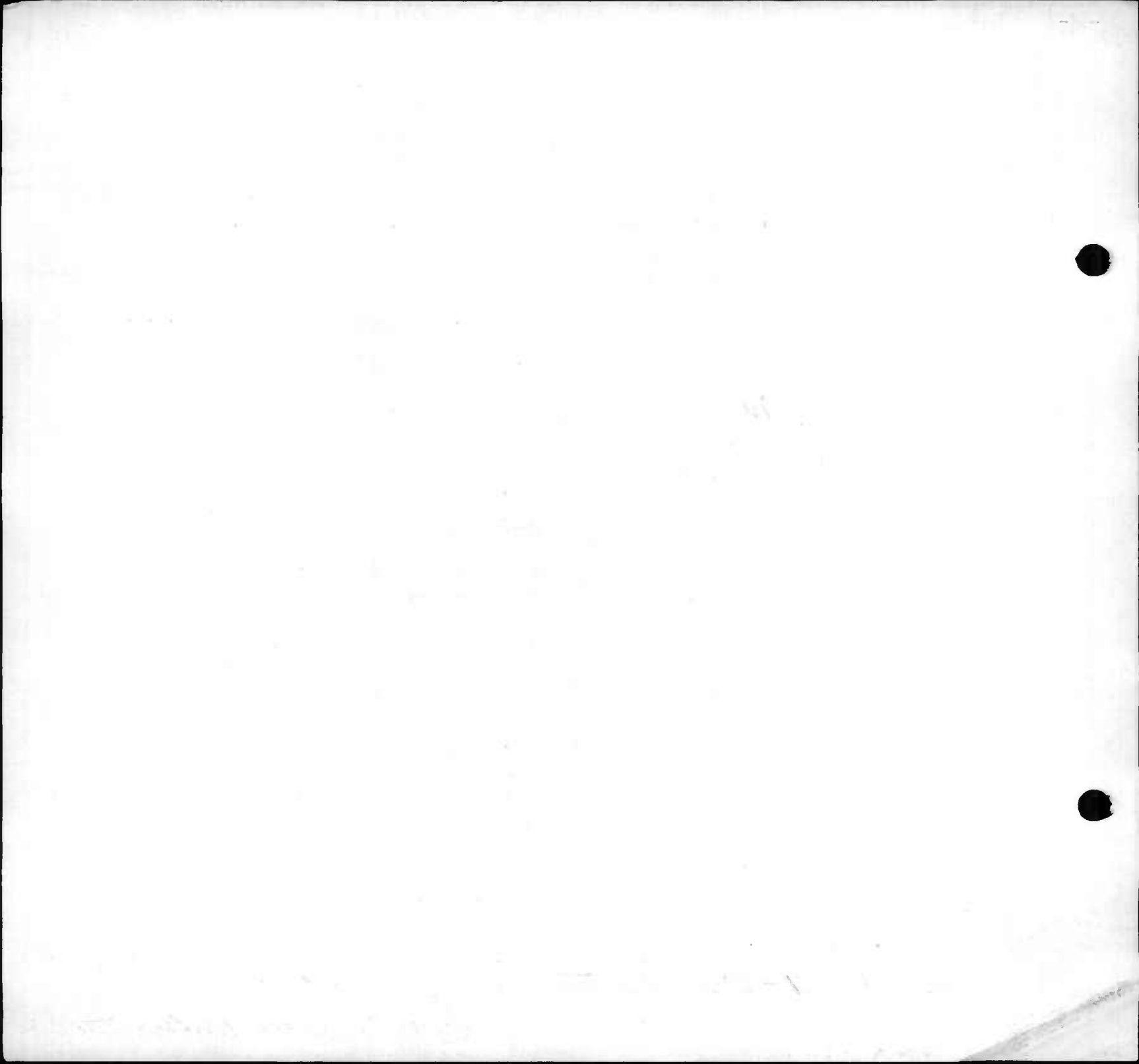
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. B650		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00834	
M.E. CASE NO. 66 00834		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BROWN, Estelle			2. DATE AND HOUR OF DEATH 1/22/66 6:45 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 9-06 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2761 Alameda Blvd - 21218		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 6/9/91	9. AGE (In years lost birthday) 74	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Joseph Green		
14. MOTHER'S MAIDEN NAME Cloann Hastings			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 246-30-5753			17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Ave., Balto. Md. 21224		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Chronic renal disease INTERVAL BETWEEN ONSET AND DEATH > 1 year ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Nephrosclerosis several years					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Congestive heart failure several years					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (N) (this hospital) attended the deceased from 1-15 19 66 to 1-22 19 66 , that (N) (we) last saw the deceased alive on 1-22 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas M. Zizic M.D.				23B. DATE SIGNED 1-22-66	
23C. PHYSICIAN'S NAME (Type) Thomas M. Zizic M.D.				23D. ADDRESS 4940 Eastern Avenue, Balto. Md. 21224 537 North Washington Street	
24A. BURIAL CREMATION, REMOVAL (Specify) Buried		24B. DATE 1-27-66		24C. NAME OF CEMETERY or CREMATORY Intentional Care	
24D. LOCATION Balto Md		24E. LOCATION (City, town or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Clayton Wilson	
ADDRESS 100 Brantley Ave					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00835	
5315 M.E. CASE NO. 66 00835		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ZACK STEVENSON		2. DATE AND HOUR OF DEATH 1/23/66 7:30P.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 8-06 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1620 N. WASHINGTON ST.			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 8/15/95	9. AGE (In years last birthday) 70	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S. CAROLINA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN STEVENSON		14. MOTHER'S MAIDEN NAME MINNIE BAINES	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) N		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS: BCH 4940 EASTERN AVE. #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) CARDIAC Arrhythmia DUE TO ANOXIA + ARTERIO-SCLEROTIC (B) GASTRO-ENTERITIS DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH MOMENT OF DEATH HEART DISEASE 1 month			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/29 1965 to 1/23 1966, that (I) (we) last saw the deceased alive on 1/23 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Leonard J. Quadracci M.D.				23B. DATE SIGNED 1/23/66	
23C. PHYSICIAN'S NAME (Type) DR. LEONARD J. QUADRACCI				23D. ADDRESS M.D. 4940 EASTERN AVENUE #21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-27-66		24C. NAME OF CEMETERY or CREMATORY Arbutus Court	
24D. LOCATION Belts		24E. (City, town, or county) MD		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1966		25B. NAME OF REGISTRAR John E. Fink		25C. FUNERAL DIRECTOR Blaylock 1000 Brantley Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

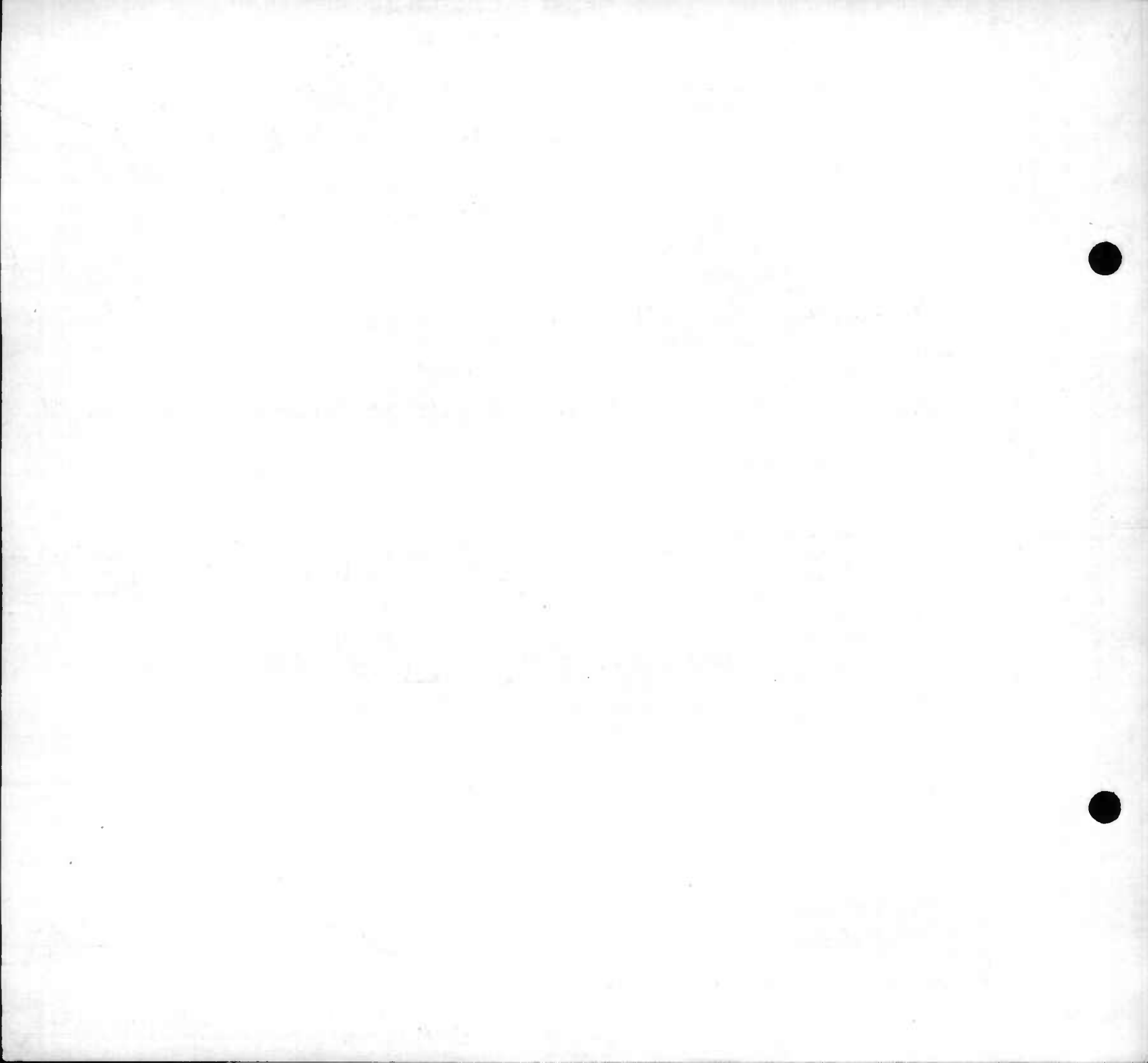
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH										Registered No. 66 00836
BIRTH NO. 66 00836										
M.E. CASE NO.										
1. NAME OF DECEASED (Type or Print) Charles E. Williams					2. DATE AND HOUR OF DEATH 1-24-66 1:00 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY 12-07					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore					
					D. STREET ADDRESS (If rural, give location) 2101 N. Howard					
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) divorced	8. DATE OF BIRTH 6-12-18	9. AGE (In years last birthday) 47	If Under 1 Yr. Months: Days: Hours: Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) janitor			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Anderson Williams					14. MOTHER'S MAIDEN NAME Eliza Lee					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW II			16. SOCIAL SECURITY NO. 220-03-2301		17. INFORMANT Corletha Hayes			ADDRESS 2328 Edmondson		
18. 603X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) Hyperkalemia (A) DUE TO					INTERVAL BETWEEN ONSET AND DEATH 18 days					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic Renal Insufficiency (B) DUE TO (C)										
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1-2 19 66 to 1-24 19 66 , that (I) (we) lost saw the deceased alive on 1-24 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Frank L. Barham, M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 1-24-66		
23C. PHYSICIAN'S NAME (Type) FRANK L. BARHAM					23D. ADDRESS Mercy Hospital Baltimore md					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-25-66		24C. NAME OF CEMETERY or CREMATORY Balto. Nat'l Cem. Balto.			24D. LOCATION (City, town, or county) (State) Md			
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1966			25B. NAME OF REGISTRAR W. J. ...			25C. FUNERAL DIRECTOR Sullivan Funeral Home - N. Arlington				

74

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH										Registered No.	
BIRTH NO. 66 00837											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) SARAH ELIZABETH WILLIAMS		2. DATE AND HOUR OF DEATH 1/20/66 252 P.M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL BALTIMORE, MD.						A. STATE MD. B. COUNTY Baltimore					
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) WOODSTOCK 5300					
						D. STREET ADDRESS (If rural, give location) ST. PAUL Ave.					
5. SEX F	6. RACE CAUC.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 10/29/86	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: Hours: Min.						
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY Home			11. BIRTHPLACE (State or foreign country) MD.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Geo. ZEPPE WILLIAMS						14. MOTHER'S MAIDEN NAME EMMA ALBRIGHT					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Mr. William Williams Woodstock Md.						
18. CAUSE OF DEATH											
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) acute pulm. edema 12 hours											
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) ASHD 10 years (B) R/O pulmonary embolism 6-12 hrs. (C) Regional elect. - Intensive Care											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION Jan 17, 1966			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intensive Care			20A. AUTOPSY? (Yes or No) NO			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (this hospital) attended the deceased from 1/15 19 66 to 1/20 19 66 , that (we) last saw the deceased alive on 1/20 19 66 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Nicholas C Bosch M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>										23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) NICHOLAS C BOSCH						23D. ADDRESS M.D. UNIVERSITY OF MARYLAND HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-23-66		24C. NAME OF CEMETERY or CREMATORY Granite Presbyterian				24D. LOCATION (City, town, or county) (State) Granite Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1966			25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR Luther H. Haight			ADDRESS Sykesville, Md.		



W 623

66 00838

BALTIMORE CITY HEALTH DEPARTMENT

66 00838

BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

CALVIN M. WRIGHT

2. DATE AND HOUR PRONOUNCED DEAD

1/23/66 1:55 a. m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Howard

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Waterloo

D. STREET ADDRESS (If rural, give location)

Sherwood Acres Trailer Park

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

May 11, 1911

9. AGE (In years last birthday)

54

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Coal Miner

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Anderson Co. Tenn.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Will Wright

14. MOTHER'S MAIDEN NAME

Dixie Everett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

232-16-6428

17. INFORMANT

ADDRESS

Roach Mortuary LaFollette, Tenn

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Massive gastro-intestinal hemorrhage, originating from erosion of gastric mucosa

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

Purulent meningitis and cranio-cerebral injury

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

U.S.1 near Montevideo Rd. 63-00

21D TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)
1 7 66 6:10 p.

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

pedestrian struck by car

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

1/23/66

23A. BURIAL CREMATION, REMOVAL (Specify)

Removal

23B. DATE

1/24/66

23C. NAME OF CEMETERY or CREMATORY

Indian Creek Cemetery

23D. LOCATION

(City, town, or county)

(State)

Jacksboro, Tenn.

24A. DATE REC'D BY HEALTH DEPT.

JAN 25 1966

24B. NAME OF REGISTRAR

Robert E. Fairbairn

24C. FUNERAL DIRECTOR

Wm. Cook-Brooks Inc. 1217 St. Paul St. 21202

ADDRESS

1/27/65 Nature of Injury - massive gastric - intestinal
hemorrhage complicating gastric mucosa
Information from Dr. Werner A. Spitz - Med. Officer.

VALLEY POLICE

LABORATORY

USA

1
H 534
H. 530

66 00839

BALTIMORE CITY HEALTH DEPARTMENT

66 00839

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

William Robert

(Handy)
Handley

2. DATE AND HOUR PRONOUNCED DEAD

1/24/66

9:50 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

538 Moore St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

5-15-1895

9. AGE (In years
last birthday)

70

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Unknown

12. CITIZEN OF
WHAT COUNTRY?

U. S. A

13. FATHER'S NAME

unk

14. MOTHER'S MAIDEN NAME

unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

ww1

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Irvin Goines

867 Boyd St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORK

NOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/25/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JAN 25 1966

Robert E. Spitz

MORTON + Dyett

1701 Laurens

WALDEY HOUSE

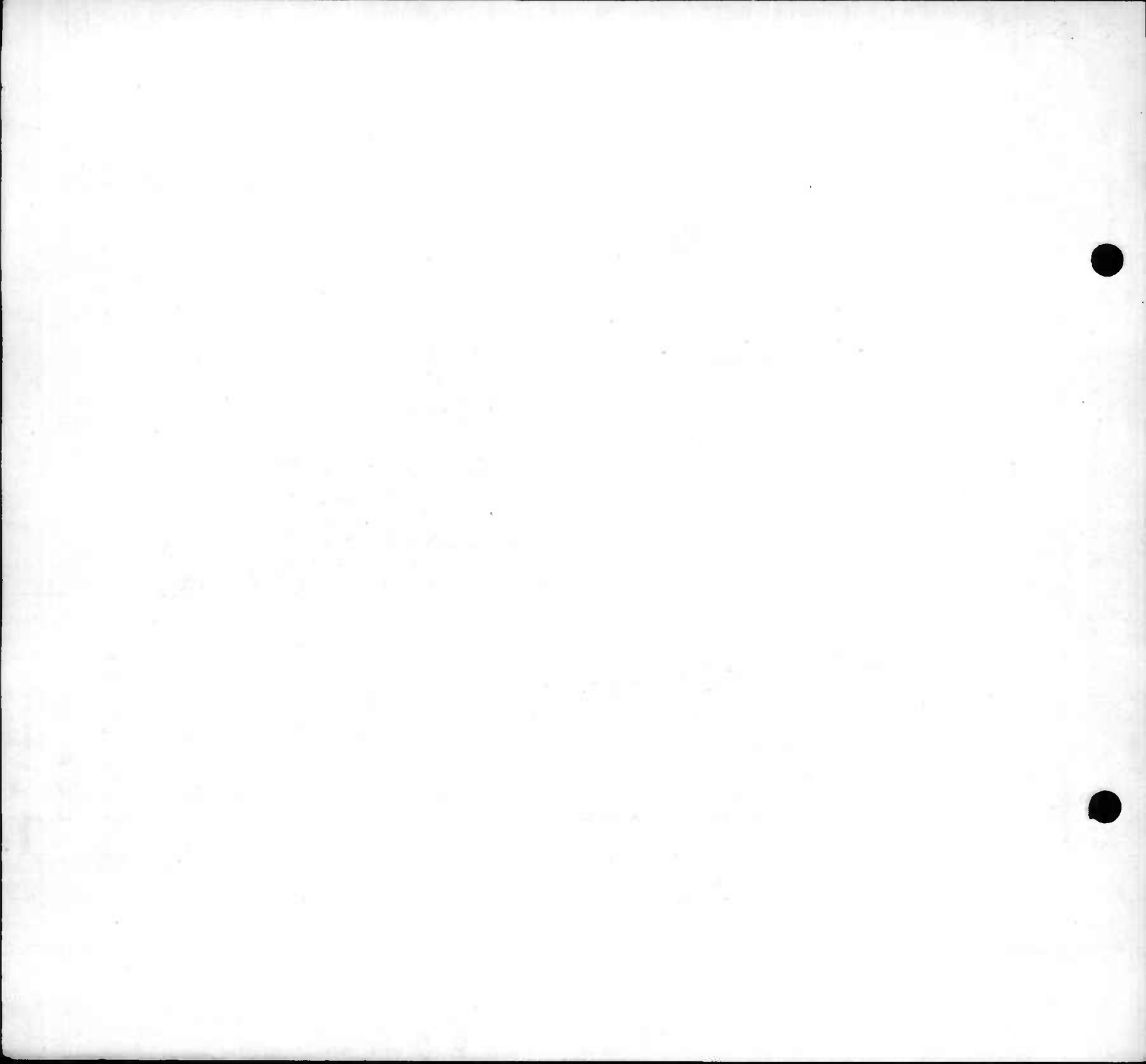
Walden

Walden

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

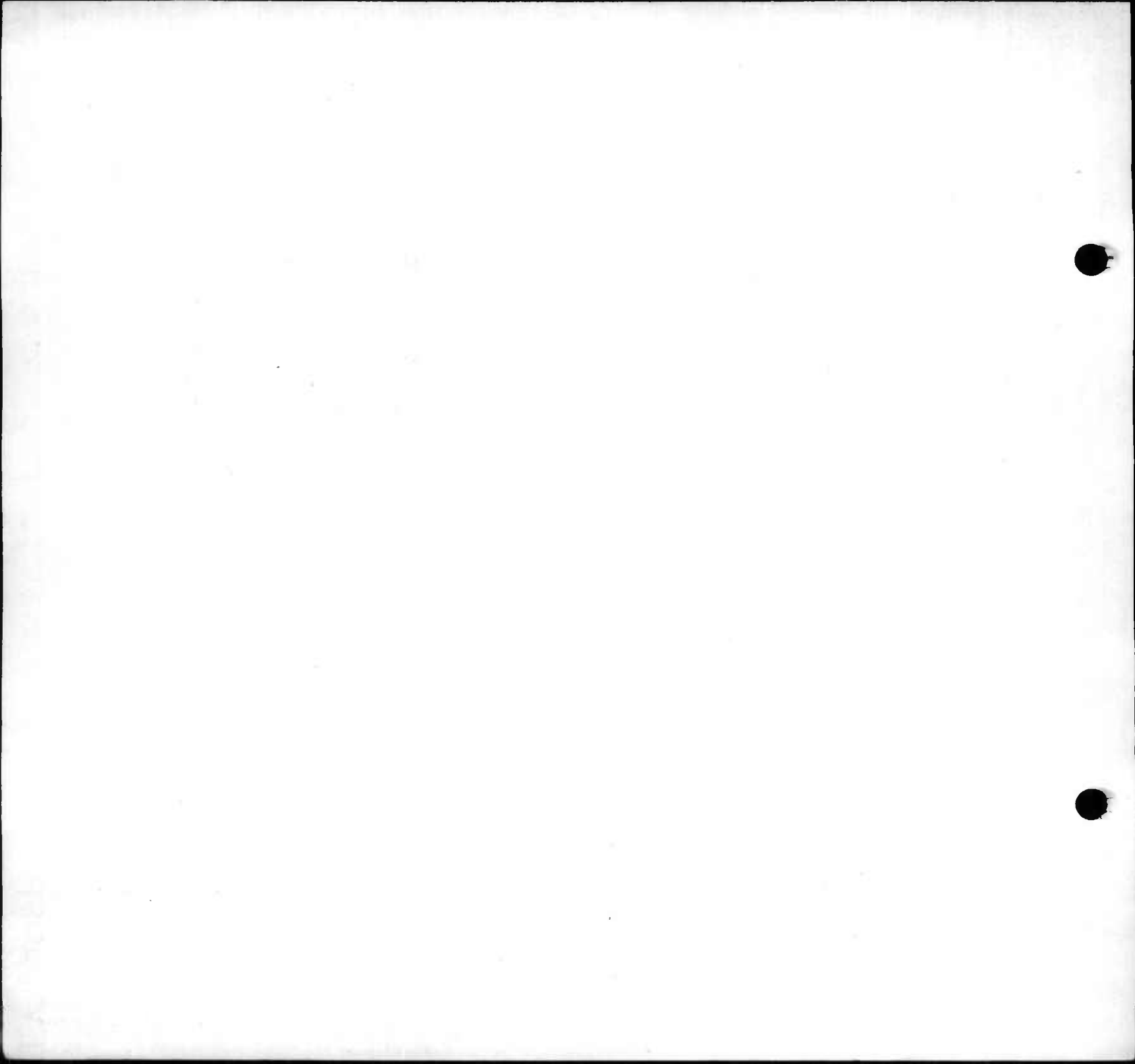
BIRTH NO. 66 00840		BALTIMORE CITY HEALTH DEPT.		CERTIFICATE OF DEATH		Registered No. 66 00840	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) Josiah Smith				JANUARY 24, 1966 6:15 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lincoln Memorial Nursing Home 27 N. Carey street				A. STATE Maryland B. COUNTY 15-12			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 2906 NorFolk Avenue			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widower	8. DATE OF BIRTH 1-1-1892	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? America
13. FATHER'S NAME Henry Smith			14. MOTHER'S MAIDEN NAME Hester Smith				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 212-18-8164		17. INFORMANT R. Smith - 2705 Springhill Ave.		ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 15 OXI				CAUSE OF DEATH (A) DUE TO base in one of esophagus (B) DUE TO lymph node cancer (C) of glands in neck		INTERVAL BETWEEN ONSET AND DEATH	
<div style="text-align: center;">II</div> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Stomach		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 17 19 66 to Jan 24 19 66 , that (I) (we) last saw the deceased alive on Jan 24 66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE MR Johnson				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) MR Johnson				23D. ADDRESS 403 Mel arts Bg			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-27-66		24C. NAME OF CEMETERY or CREMATORY MT. Auburn		24D. LOCATION (City, town, or county) (State) Ba Md. Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Morgan Dett		ADDRESS 1701 Laurens ST.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

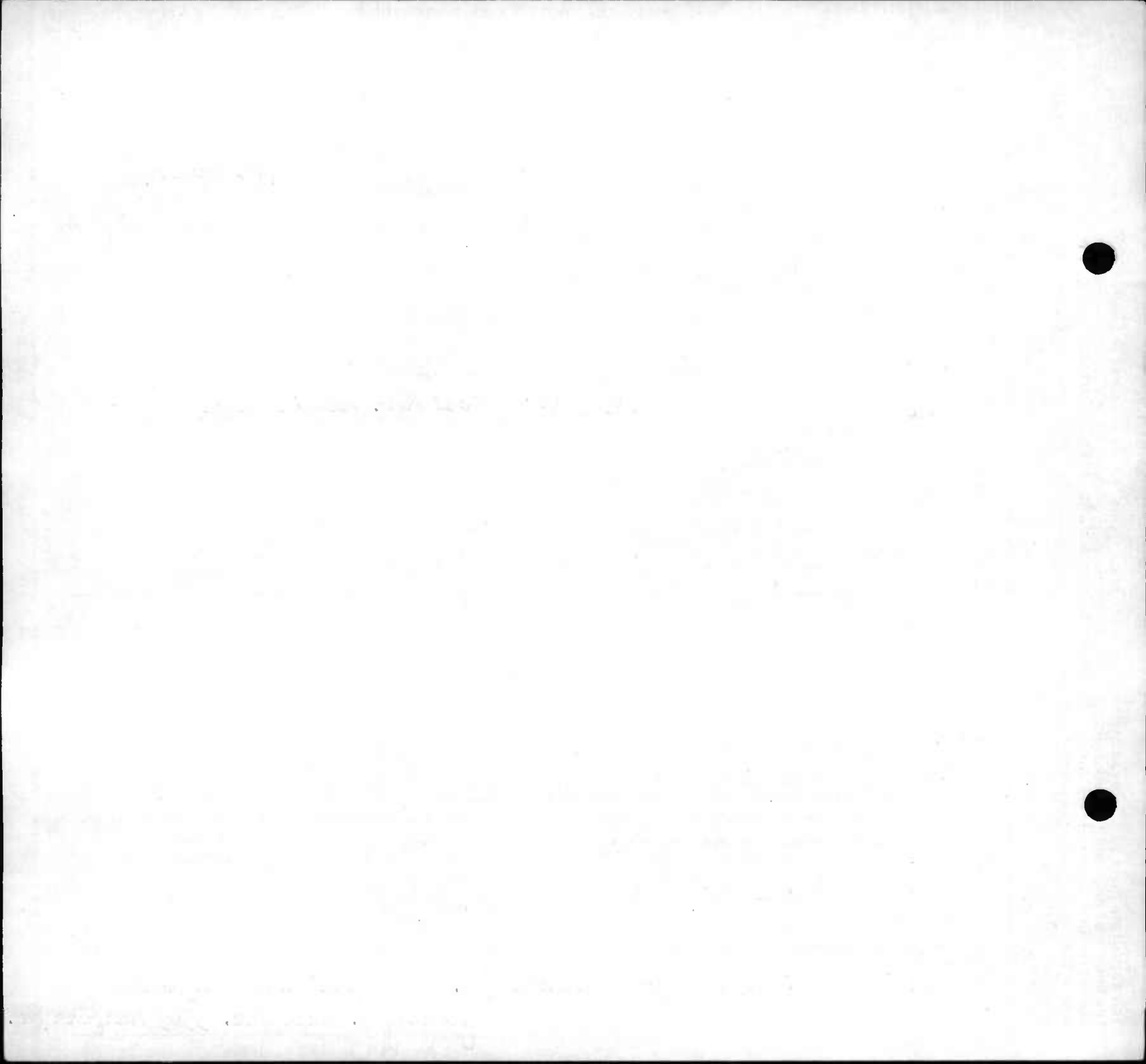
BIRTH NO. 66 00841				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 00841	
1. NAME OF DECEASED (Type or Print) <u>Portee, Chester</u>				2. DATE AND HOUR OF DEATH <u>24 Jan. 66</u> <u>7¹⁰</u> <u>P. M.</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto.</u> <u>25-32</u>			
				D. STREET ADDRESS (If rural, give location) <u>2745 Round Rd</u>					
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>5-15-90</u>	9. AGE (In years last birthday) <u>75</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>steel</u>		11. BIRTHPLACE (State or foreign country) <u>S. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Willie Portee</u>				14. MOTHER'S MAIDEN NAME <u>Carrie House</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>216-07-9279</u>		17. INFORMANT ADDRESS <u>Mrs. PORTEE 2745 Round Rd.</u>				
18. <u>331X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(A) <u>Cerebral vascular accident</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>16 Dec 65</u>			
				(B) <u>Cerebral vascular disease</u> DUE TO		?			
				(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>16 Dec 65</u> to <u>24 Jan 66</u> , that (I) (we) last saw the deceased alive on <u>24 Jan 66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Richard P. Norgaard</u> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>24 Jan 66</u>		
23C. PHYSICIAN'S NAME (Type) <u>RICHARD P. NORGAARD</u> M.D.					23D. ADDRESS <u>University Hospital</u>				
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-27-66</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Carver Mem</u>		24D. LOCATION (City, town, or county) (State) <u>Laurel Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1966</u>			25B. NAME OF REGISTRAR <u>Robert J. Stedman</u>		25C. FUNERAL DIRECTOR ADDRESS <u>NORBERT + DYE TT Fyn. H. 1701 Laurens</u>				



FUNERAL DIRECTOR: IMPORTANT

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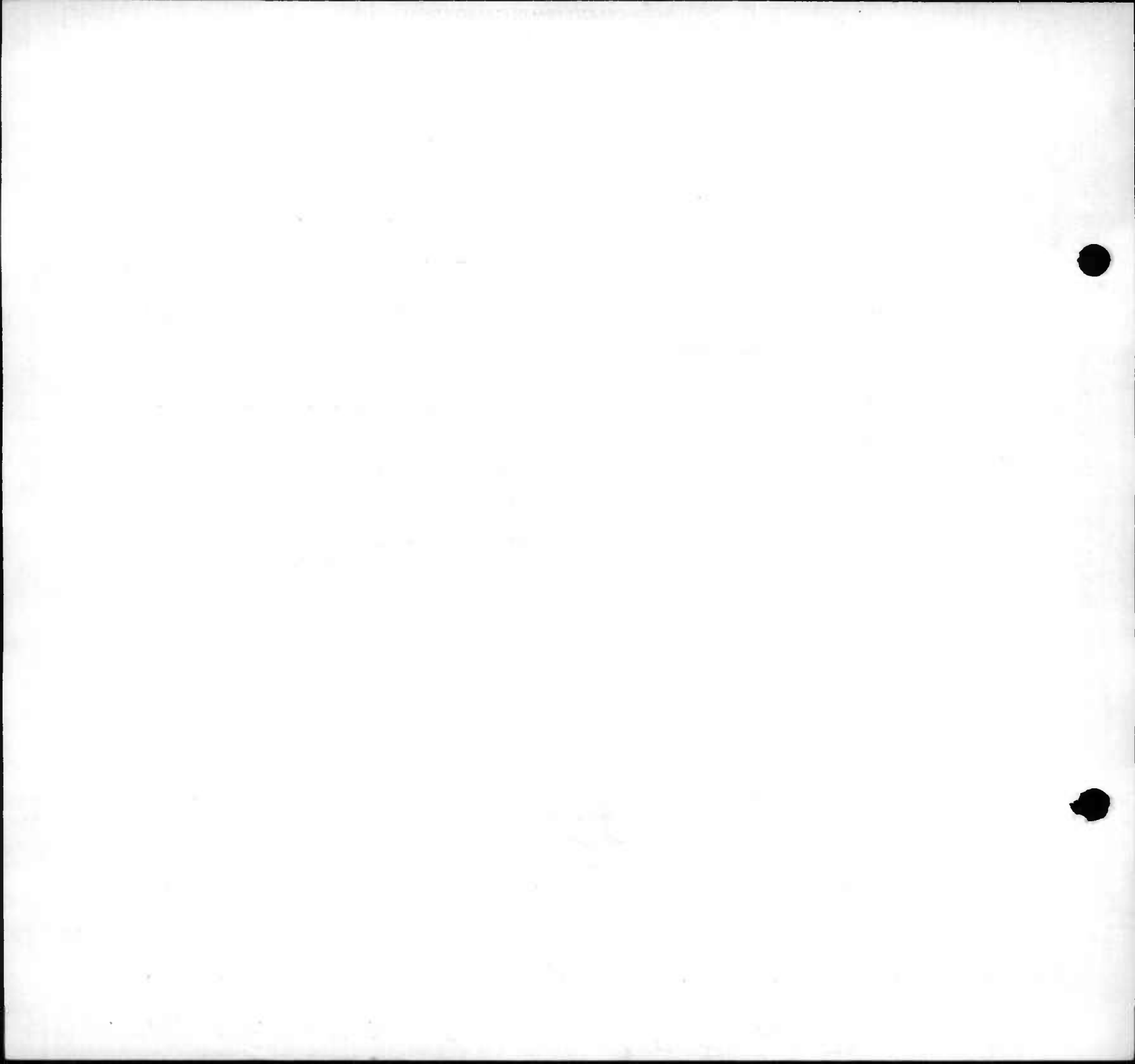
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 66 00842	
BIRTH NO. 66 00842		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MURPHY, THOMAS A.		2. DATE AND HOUR OF DEATH 1-25-66 14 55 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BON SECOURS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE (Parkville) 6300 D. STREET ADDRESS (If rural, give location) 3007 PUTTY HILL AVE (21234)			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 11/5/76	9. AGE (In years last birthday) 89	10. CITIZEN OF WHAT COUNTRY? UNITED STATES	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME TERRENCE MURPHY				14. MOTHER'S MAIDEN NAME MARGARET HANSON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705050016A		17. INFORMANT Most Rev. Austin Murphy		ADDRESS 3803 FOURTH ST. BALTO, 25, MD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cancer of Descending Colon				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Sept. 25 19 65 to Jan. 25 19 66 , that (I) (we) lost saw the deceased alive on Jan. 25 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Josephine Bruñidor				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Jan. 25, 1966	
23C. PHYSICIAN'S NAME (Type) Josephine Bruñidor				23D. ADDRESS M.D. Bon Secours Hsp. Baltimore, Maryland 21223			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/28/66		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.		ADDRESS 5305 Harford Rd.	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00843	
BIRTH NO. 66 00843		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Harry Stein			2. DATE AND HOUR OF DEATH Jan 22, 1966 6:45 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Century Nursing Home 122 No. Paca St.			A. STATE Md. B. COUNTY 4-02		
5. SEX Male			C. CITY OR TOWN Baltimore		
6. RACE White			D. STREET ADDRESS (If rural, give location) 102 No. Paca St.		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single			8. DATE OF BIRTH 12-26-1880		
9. AGE (In years last birthday) 85			10. CITIZEN OF WHAT COUNTRY? USA		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			11. BIRTHPLACE (State or foreign country) Maryland		
10B. KIND OF BUSINESS OR INDUSTRY Unknown			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown			16. SOCIAL SECURITY NO.		
17. INFORMANT ADDRESS Records, Century Nursing Home					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) Cardio-Respiratory Failure (B) Cerebral Vascular Accident (massive) (C) Aortic Aneurysm		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Oct 21 1964 to Jan 22 1966, that (I) (we) last saw the deceased alive on Jan 22 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE William Appleford			23B. DATE SIGNED 1/24/66		
23C. PHYSICIAN'S NAME (Type) William Appleford			23D. ADDRESS M.D. 5501 Park Heights N. Balto Md		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 1/26/66		
24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1966			25B. NAME OF REGISTRAR Robert E. Taylor		
25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Baltimore, Md.			ADDRESS		



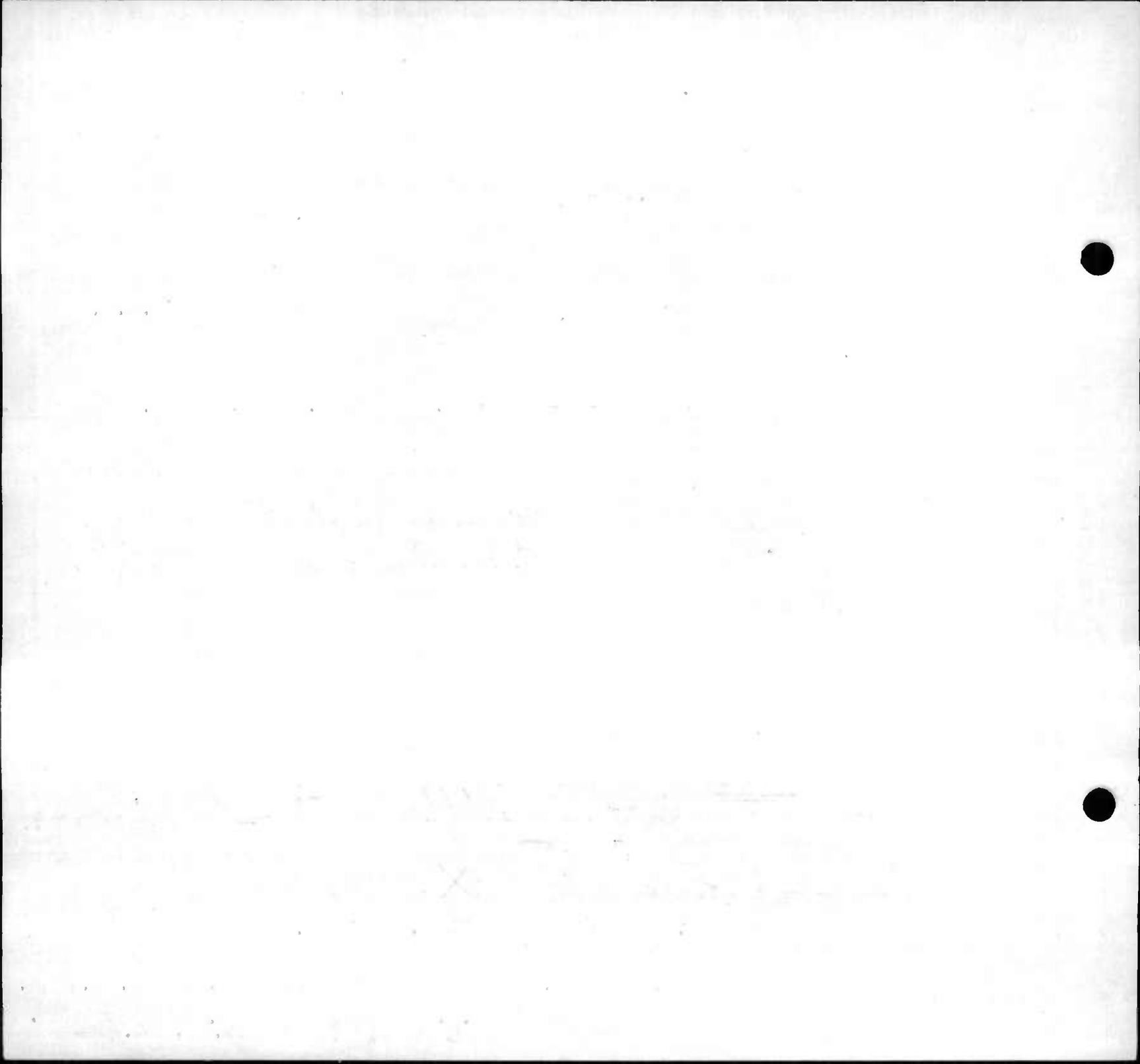
FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00844	
BIRTH NO. 66 00844		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) KOSKER, ELIZABETH Ann		2. DATE AND HOUR OF DEATH 1-25-1966 9:35 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 26-03			
FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 3006 Brendan Ave. #6			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED Married	8. DATE OF BIRTH 10/8/1903	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Joseph Kernan		14. MOTHER'S MAIDEN NAME ? Caton			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Virgil F. Kosker-- Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 05312		CAUSE OF DEATH (A) CARDIOVASCULAR COLLAPSE DUE TO (B) RENAL FAILURE DUE TO (C) GRAM NEGATIVE SEPTICEMIA		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 1-10-1966 to 1-25-1966 , that (H) (we) last saw the deceased alive on 1-25-66 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph Notarangelo		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-25-66	
23C. PHYSICIAN'S NAME (Type) JOSEPH NOTARANGELO		23D. ADDRESS MERCY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/29/66		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	
		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Buck Inc. 5305 Harford Rd.	

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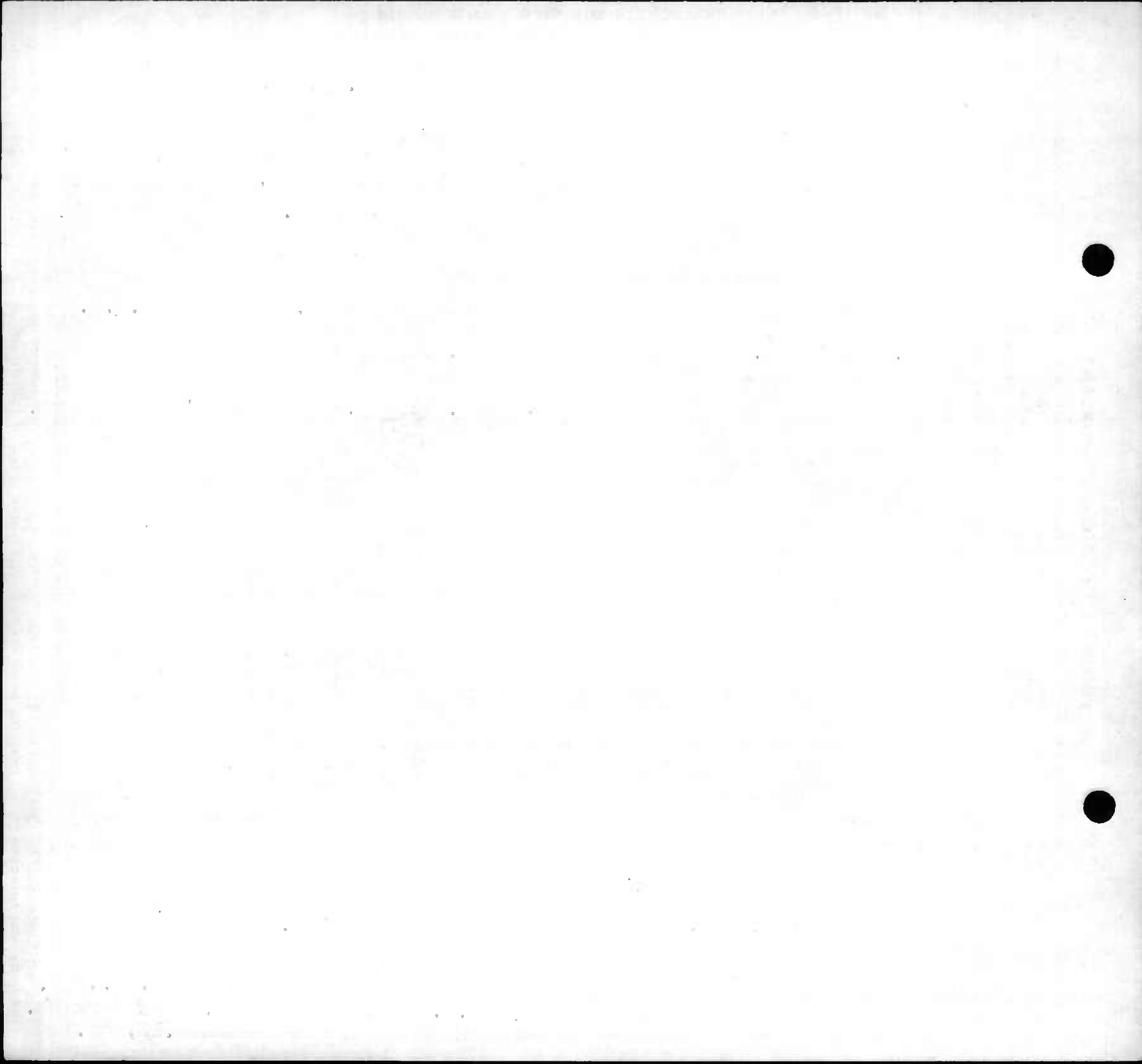
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>66 00845</u>	
BIRTH NO. <u>66 00845</u>							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <u>Irma A. Crowther</u>				2. DATE AND HOUR OF DEATH <u>Jan. 23, 1966</u> <u>3:50 P.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Homewood Apts., 1-D</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>12-02</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>Homewood Apts. 1-D</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>10/23/1878</u>	9. AGE (In years last birthday) <u>87</u>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John M. Megraw</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Ryan</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-26-9377</u>		17. INFORMANT <u>Mrs. Leonard I. Davis, 4508 N. Charles St.</u>			
18. <u>450.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <u>Uremia</u> DUE TO (B) <u>Glomerular nephritis</u> DUE TO (C) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u> <u>1 yr.</u> <u>8 yr.</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from <u>1/1</u> 19 <u>58</u> to <u>Jan 23</u> 19 <u>66</u> . that (I) (we) last saw the deceased alive on <u>Jan 22</u> 19 <u>64</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Norman R. Freeman</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>11/24/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Norman R. Freeman</u>				23D. ADDRESS <u>11 W. 29th St.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/25/1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>Sherwood Church</u>		24D. LOCATION (City, town, or county) (State) <u>Cockeysville, Balto. Co., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co., 4905 York Rd. Balto. 12, Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

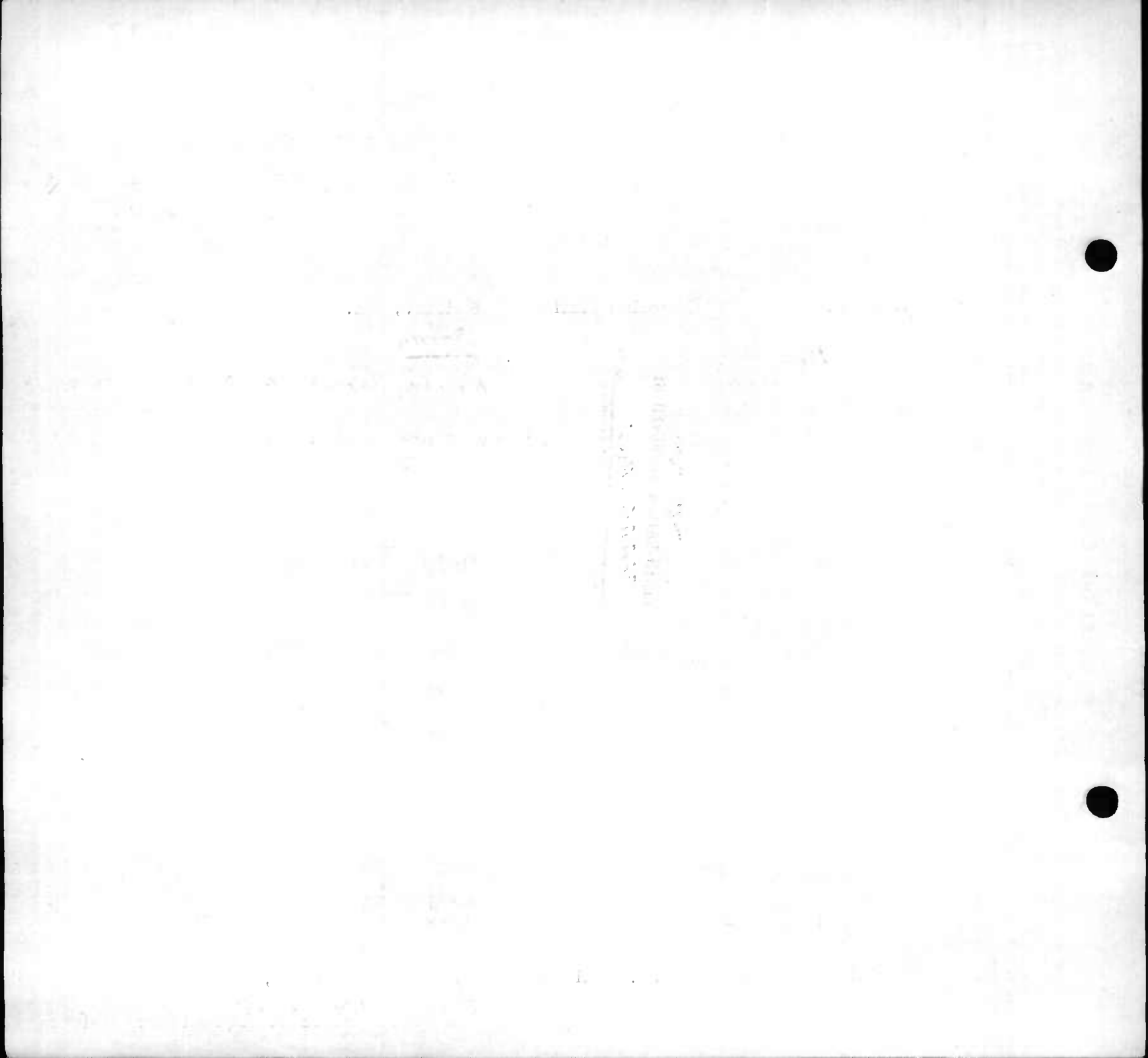
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>66 00846</u>	
BIRTH NO. <u>66 00846</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Maud Wiegand Mattingly</u>		2. DATE AND HOUR OF DEATH <u>Jan. 23, 1966</u> <u>4:30 AM</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Hillcrest Nursing Home</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>13-07</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>4146 Roland Ave.</u> D. STREET ADDRESS (If rural, give location) <u>Baltimore, Md.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 8, 1883</u>	9. AGE (In years last birthday) <u>82</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dr. William E. Wiegand</u>				14. MOTHER'S MAIDEN NAME <u>E. Florence Green</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-44-2872</u>		17. INFORMANT ADDRESS <u>Mrs. Irene W. Penniman, 4614 Roland Ave.</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>450.0 I</u> <u>Interosclerosis</u>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u>	
<p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
<p>22. I certify that (I) (this hospital) attended the deceased from <u>1942</u> to <u>January 1966</u>, that (I) (we) last saw the deceased alive on <u>Jan 23 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (ard) (did not) view the body after death.</p>							
23A. SIGNATURE <u>William G. Helfrich</u>				23B. DATE SIGNED <u>1-24-66</u>			
23C. PHYSICIAN'S NAME (Type) <u>William G. Helfrich</u>				23D. ADDRESS <u>5006 Roland Ave.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/25/1966</u>		24C. NAME OF CEMETERY or CREMATORY <u>Druid Ridge</u>		24D. LOCATION (City, town, or county) (State) <u>Pikesville, Balto. Co., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

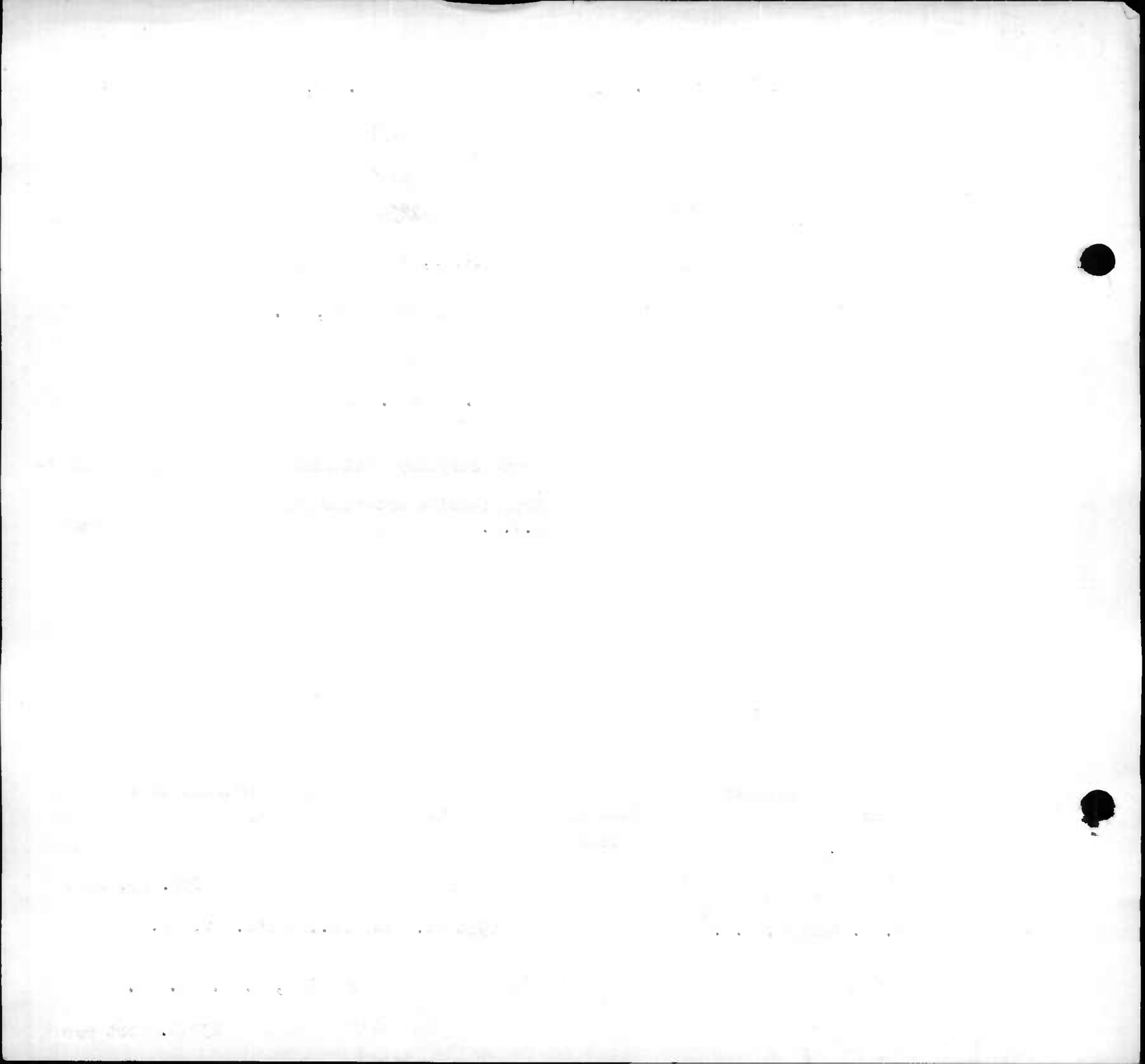
No. 66-00847

VS 150-REV. 1/1/65



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

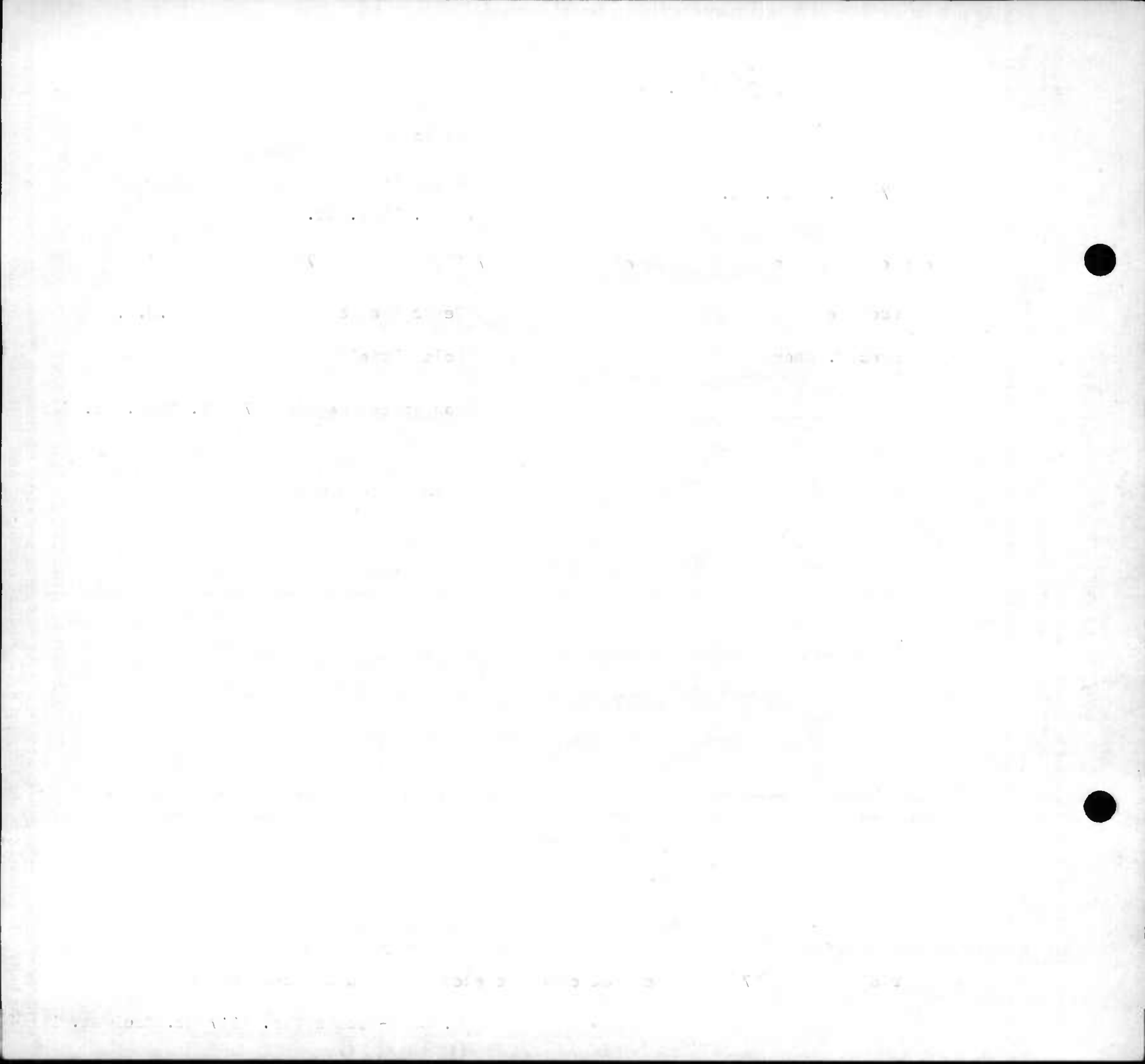
66 00848		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00848	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				Catherine C. Simmons	
2. DATE AND HOUR OF DEATH		Jan. 24, 1966		2:45 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		A. STATE Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
Marhland General Hospital		D. STREET ADDRESS (If rural, give location)		1230 Battery Ave	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH June 2, 1911	9. AGE (In years last birthday) 54	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Eastern Shore, Md.		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Jackson Tolson		14. MOTHER'S MAIDEN NAME Goldie Gardner		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Mr. John R. Simmons		ADDRESS 400 7th Ave Glen Burnie	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) Acute coronary occlusion DUE TO Hypertensive arteriosclerotic (B) C.V.D. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 5 minutes +- 15 years +	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (Name of Physician) attended the deceased from 19 45 to present time 19 66, that (I) (Name of Physician) last saw the deceased alive on January 8 19 66 and that in (my) (your) opinion death occurred on the date and hour and from the causes stated above. (I) (Name of Physician) (did not) view the body after death.					
23A. SIGNATURE <i>R. V. Rangle</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Jan. 25, 1966	
23C. PHYSICIAN'S NAME (Type) R. V. Rangle, M.D.		23D. ADDRESS M.D. 2938 St. Paul St., Balto. 18, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1 27 1966		24C. NAME OF CEMETERY or CREMATORY Cedar Hill	
24D. LOCATION Brooklyn, A. A. Co. Md.		24E. DATE REC'D BY HEALTH DEPT. JAN 26 1966		24F. NAME OF REGISTRAR Mc Cully	
24G. FUNERAL DIRECTOR 130 E. Fort Ave		24H. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00849	
BIRTH NO. 66 00849		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Honora (Hannah) C. Redding			
2. DATE AND HOUR OF DEATH 1-24-66 11 A.M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION 701 E. 33rd. St.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 701 E. 33rd. St.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 7/21/86	9. AGE (In years last birthday) 79	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James P. Ahern			14. MOTHER'S MAIDEN NAME Helen Friel		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Miss Eileen Redding 701 E. 33rd. St. #18	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2-3 years.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 1 1962 to January 14 1966, that (I) (we) last saw the deceased alive on January 14 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Philip D. Flynn		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1-25-66	
23C. PHYSICIAN'S NAME (Type) Philip D. Flynn		23D. ADDRESS 11 E. Chase St 21302			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/27/66		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 26 1966			
25B. NAME OF REGISTRAR Wm. Cook-Brooks Inc.		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Inc. 1217 St. Paul St. 21202			



BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

ROSA LILLIAN ROSA GANAS

2. DATE AND HOUR PRONOUNCED DEAD

1-23-66

9:25 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

FRANKLIN SQUARE HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

205 S. Parrish Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

7/7/25

9. AGE (In years
last birthday)

40

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Waitress

10B. KIND OF BUSINESS OR INDUSTRY

Resturant

11. BIRTHPLACE (State or foreign country)

Roanoke, Va.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Dalton

14. MOTHER'S MAIDEN NAME

Sarah (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

224-24-0277

17. INFORMANT

Alice Ferguson

ADDRESS

4165 Fairview Ave.

Baltimore, Md. 21216

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

Bronchopneumonia

~~XXXXXX~~

Complicating subdural hemorrhage

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Unknown

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Unknown

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

Unknown

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Unknown - Probable fall

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-24-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1/26/66

23C. NAME of CEMETERY or CREMATORY

Meadowridge Memorial

23D. LOCATION

(City, town, or county)

(State)

Howard County, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JAN 26 1966

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

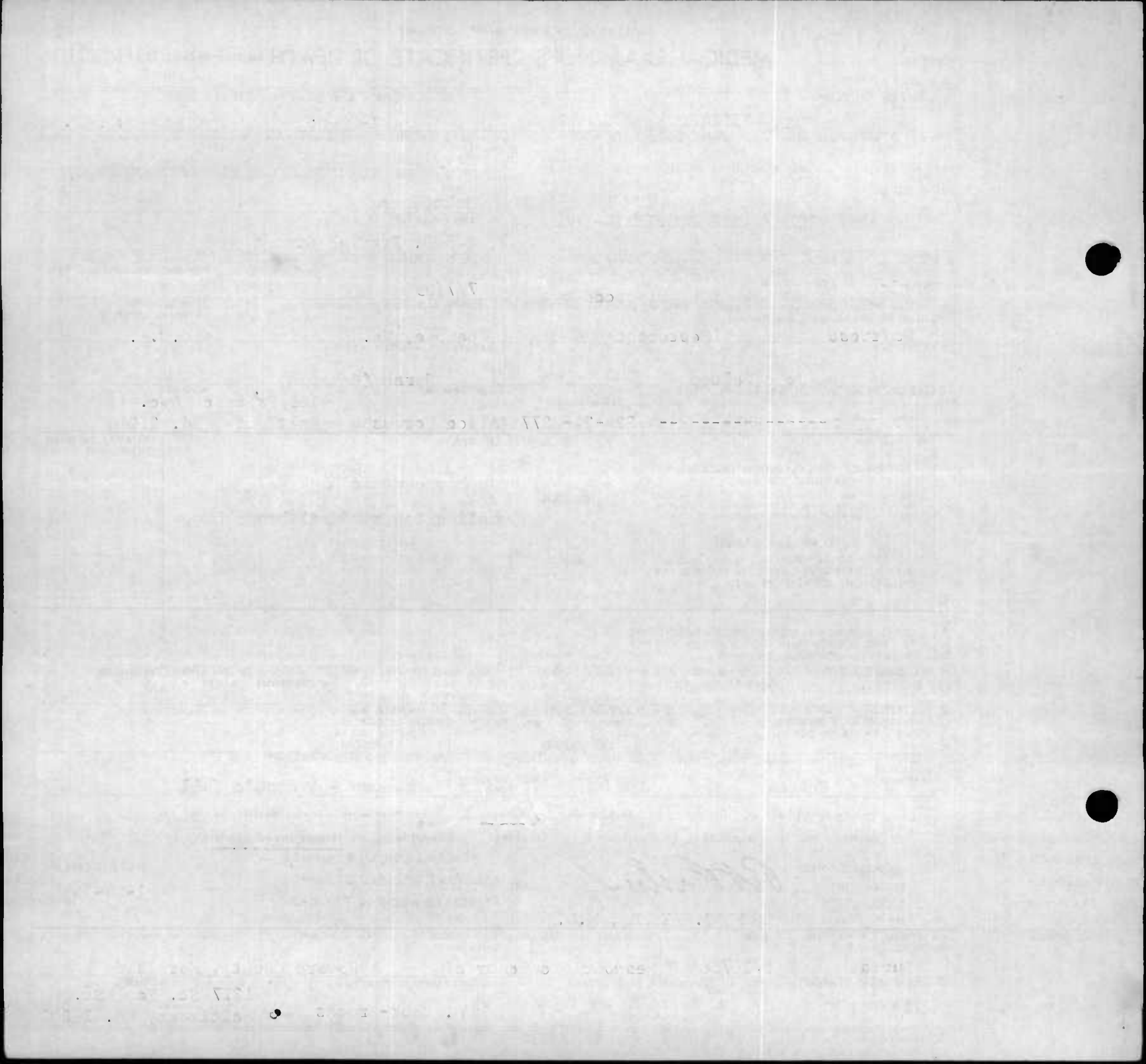
24C. FUNERAL DIRECTOR

Wm. Cook-Brooks Inc

ADDRESS

1217 St. Paul St.

Baltimore, Md. 21202



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00851		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 00851	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) PEAK, RODNEY EDWIN		2. DATE AND HOUR OF DEATH JAN. 24, 1966 8 45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL 3-18-66		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY HARFORD C. CITY OR TOWN (If outside city limits, write RURAL and give township) JESSUP D. STREET ADDRESS (If rural, give location) ANNAPOLIS JCT.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 3/19/1896	9. AGE (In years last birthday) 72 69
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NEW JERSEY	
13. FATHER'S NAME CHARLES PEAK		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. —		17. INFORMANT ADDRESS MEDICAL RECORDS	
18. 433.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) BRAIN STEM INFARCTION DUE TO (B) VENTRICULAR TACHYCARDIA DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH 6 hrs		19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 19 19 66 to January 24 19 66 , that (I) (we) last saw the deceased alive on January 24 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Barry N. Rosenbaum				23B. DATE SIGNED 1/24/66	
23C. PHYSICIAN'S NAME (Type) BARRY N. ROSENBAUM		23D. ADDRESS UNIVERSITY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE Jan. 25, 66		24C. NAME OF CEMETERY or CREMATORY Baptist Cemetery	
24D. LOCATION (City, town, or county) (State) Pemberton, New Jersey		25A. DATE REC'D BY HEALTH DEPT. JAN 26 1966			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks, Inc. 1217 St. Paul St.			

Birth Cert. from New Jersey

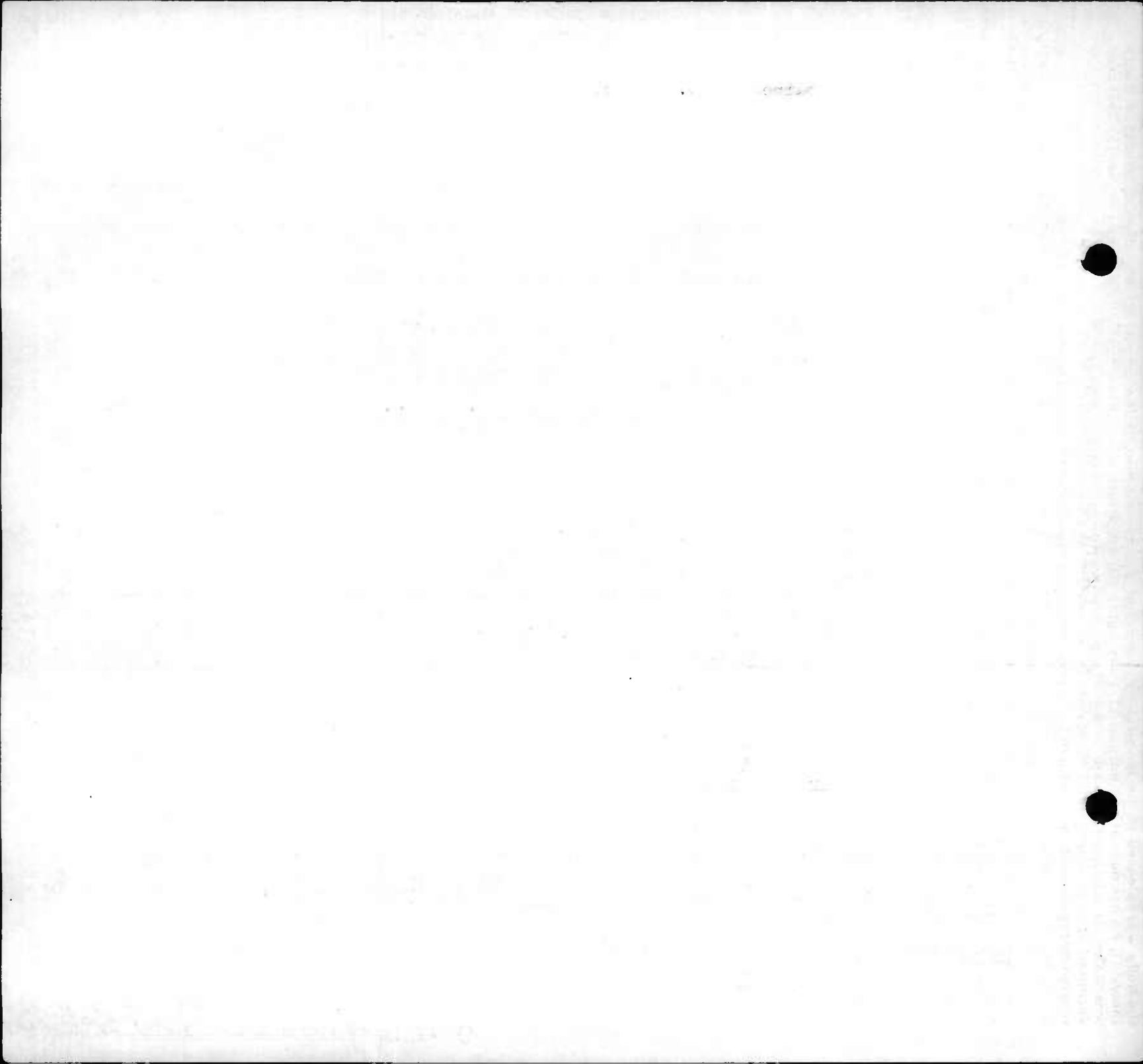
3-18-66

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

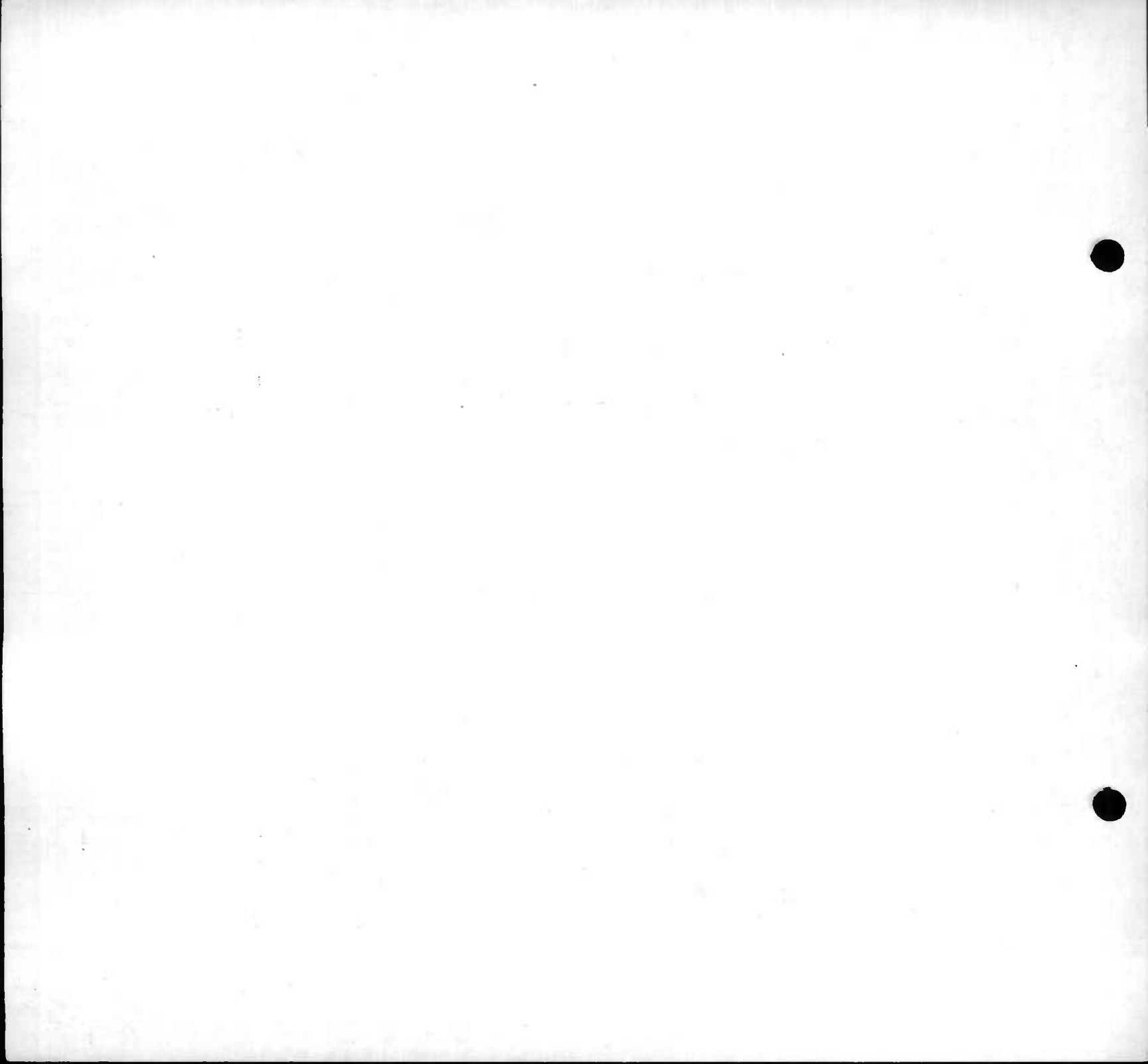
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 66 00852		CERTIFICATE OF DEATH		66 00852	
1. NAME OF DECEASED (Type or Print) Adeline E. Heim		2. DATE AND HOUR OF DEATH 1/25/66 6 20 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 34 Bon Secours Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Howard C. CITY OR TOWN (If outside city and give township) Ellicott City D. STREET ADDRESS (If rural, give location) 40 Normandy Dr			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2/21/91	9. AGE (In years last birthday) 74	If Under 1 Tr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore	
13. FATHER'S NAME John BRADER		14. MOTHER'S MAIDEN NAME Louise Bierman		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Mr. John J. Heim same address as above	
18. 4 20, 1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction		CAUSE OF DEATH (A) DUE TO Myocardial Infarction (B) DUE TO Congestive Heart Failure (C) _____		INTERVAL BETWEEN ONSET AND DEATH 8 days 8 days	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from JANUARY - 17th 1966 to JANUARY - 25th 1966 , that (I) (we) last saw the deceased alive on JANUARY - 25th 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Angel S. Gargales M.D.				23B. DATE SIGNED 1-25-1966	
23C. PHYSICIAN'S NAME (Type) _____				23D. ADDRESS M.D. _____	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/28/1966		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 26 1966		25B. NAME OF REGISTRAR James J. ...	
25C. FUNERAL DIRECTOR James J. ...		25D. ADDRESS Baltimore, Md. 17 North ... Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

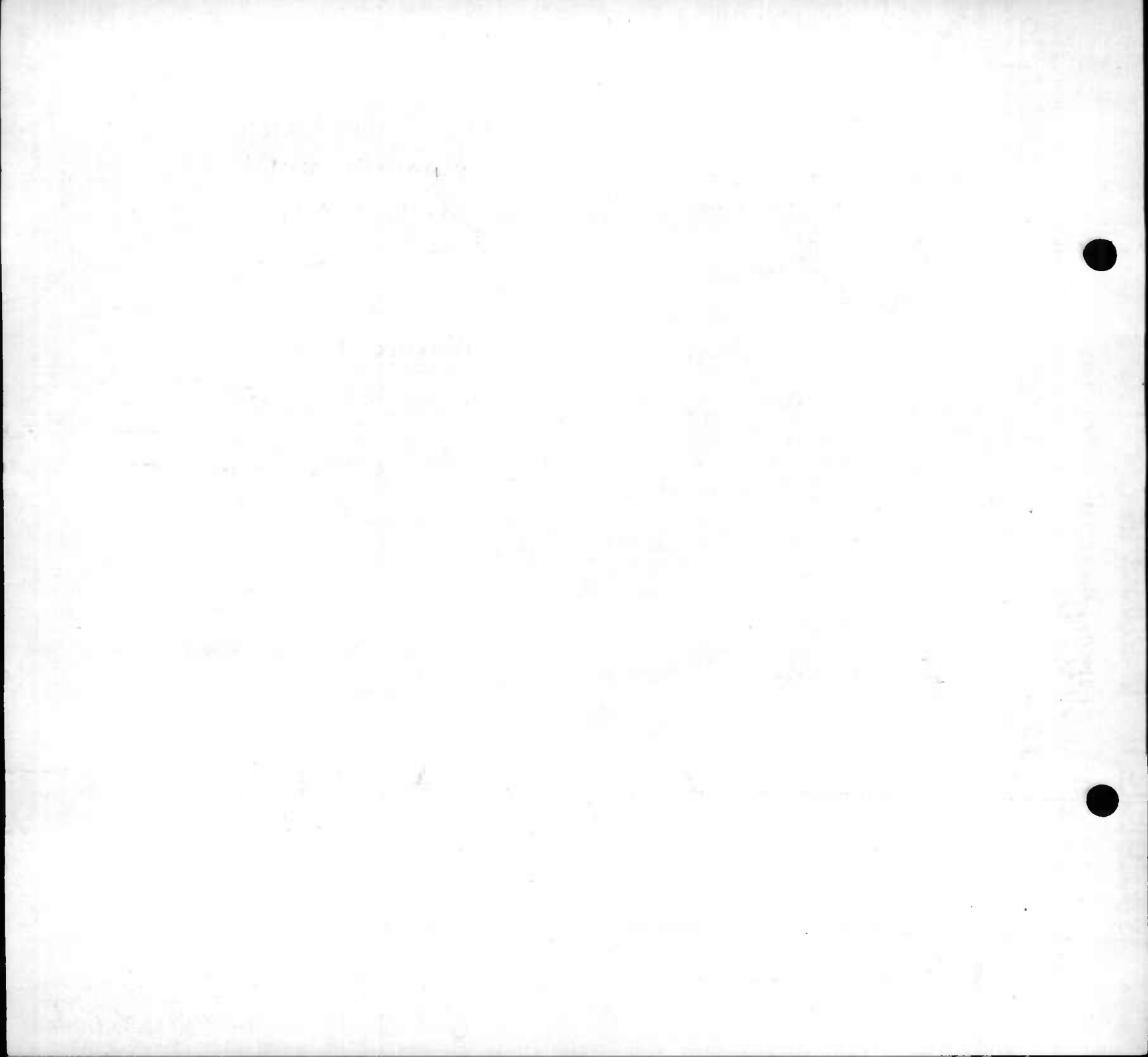
BALTIMORE CITY HEALTH DEPARTMENT						Registered No. 66 00853	
BIRTH NO. 66 00853				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Woodward Monroe A.				2. DATE AND HOUR OF DEATH 1/24/66 7:20 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND 46 Lutheran Hospital of Maryland				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY 7-02			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 Lutheran Hospital of Maryland				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
D. STREET ADDRESS (If rural, give location) 712 N. KENWOOD AVE				E. CITY OR TOWN (If rural, give location) 21205			
5. SEX Male	6. RACE W. S.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3-11-01	9. AGE (in years last birthday) 64	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Jesse A. Woodward				14. MOTHER'S MAIDEN NAME Constanza Witte			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War II				16. SOCIAL SECURITY NO. 217-01-6943		17. INFORMANT ADDRESS Mrs. Bertha Florence Woodward same address	
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) C. V. A. Coronary artery DUE TO 1-24-66 (B) Diabetes Mellitus DUE TO (C) Aspiration Pneumonia		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1/18 19 66 to 1/24 19 66 , that (I) (we) last saw the deceased alive on 1/24 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Cheng Soo Shun				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/24/66	
23C. PHYSICIAN'S NAME (Type) Leon Ashman				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/28/66		24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1966		25B. NAME OF REGISTRAR Wm. A. Jackson		25C. FUNERAL DIRECTOR Baltimore, Md. 17			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

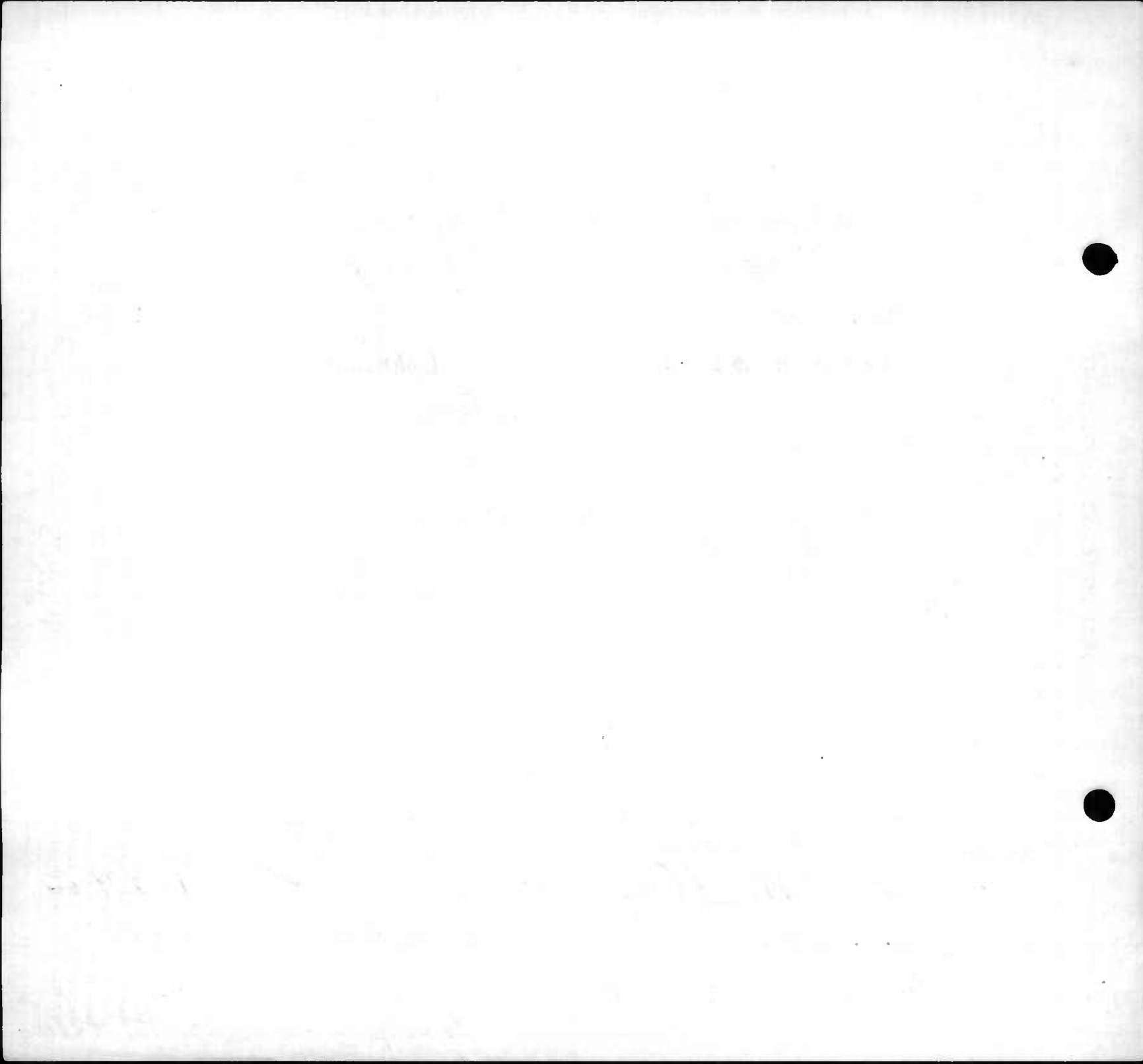
BALTIMORE CITY HEALTH DEPARTMENT											
Certificate of Death											
Registered No. 66 00854											
BIRTH NO. <u>Washington Co., Md.</u>											
M.E. CASE NO. <u>66 00854</u>											
1. NAME OF DECEASED (Type or Print) <u>Beverly E. Weedon</u>						2. DATE AND HOUR OF DEATH <u>12:45 a.m. 1/23/66</u> M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <u>John Hopkins Hospital</u> <u>Baltimore, Md.</u>						A. STATE <u>Md.</u> B. COUNTY <u>Frederick</u>					
(If not in hospital or institution, give street address or location)						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Knoxville, Md</u> <u>60-00</u>					
						D. STREET ADDRESS (If rural, give location) <u>Rt. 1, Box 176</u>					
5. SEX <u>F</u>		6. RACE <u>N</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <u>6/20/63</u>		9. AGE (In years last birthday) <u>27 1/2</u>		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child</u>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Md</u> <u>Washington Co. Hosp.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Weedon</u>						14. MOTHER'S MAIDEN NAME <u>Maxine Turner</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> <u>NO</u>						16. SOCIAL SECURITY NO.		17. INFORMANT <u>MAXINE A. Weedon Rt 1-Box 176</u>			
18. <u>744.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> (A) <u>Cardio Respiratory Arrest</u> DUE TO (B) <u>Myasthenia Gravis</u> DUE TO (C) <u>Pneumonia</u> INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hour</u>											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <u>None 1/22/66</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Tracheostomy</u>				20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., home, farm, factory, street, office bldg., etc.) <u>No</u>				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>January 22</u> 19 <u>66</u> to <u>January 23</u> 19 <u>66</u> . that (I) (we) last saw the deceased alive on <u>January 23</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Sarah D. Blumenschein</u>						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>January 23, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>Sarah D. Blumenschein</u>						23D. ADDRESS M.D. <u>Johns Hopkins Hospital, Dept. of Ped.</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>				24B. DATE <u>1-26-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Sunnyside Church</u>				24D. LOCATION (City, town, or county) (State) <u>Frederick Co Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1966</u>				25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>				25C. FUNERAL DIRECTOR <u>G. E. Hicks III</u> <u>Frederick, Md</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00855		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 00855	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Ida L. Greenstreet</i>		2. DATE AND HOUR OF DEATH <i>1-23-66 11:05 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>25-04</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #21225</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>South Baltimore General Hosp.</i>		D. STREET ADDRESS (If rural, give location) <i>412 Pontiac Ave.</i>			
5. SEX <i>F</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>9-12-1876</i>	9. AGE (In years last birthday) <i>89</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>W.V.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Family</i>	
18. <i>422.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>CVA</i>		CAUSE OF DEATH		ADDRESS <i>Same</i>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO <i>ASCVD</i>		(B) DUE TO	
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that this (this hospital) attended the deceased from <i>1-23</i> 19 <i>66</i> to <i>1-23</i> 19 <i>66</i> , that we (we) last saw the deceased alive on <i>1-23</i> 19 <i>66</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Dr. M. Kaufman</i>				23B. DATE SIGNED <i>1-24-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr. M. Kaufman</i>				23D. ADDRESS <i>South Baltimore General Hospital</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-27-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Glen Haven</i>	
24D. LOCATION (City, town, or county) (State) <i>Glen Burnie Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 26 1966</i>		25B. NAME OF REGISTRAR <i>Robert E. Stalvey</i>	
25C. FUNERAL DIRECTOR <i>Mc Culley</i>		ADDRESS <i>237 Pot. Ave.</i>			



CERTIFICATE OF DEATH

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Catherine Dick

2. DATE AND HOUR OF DEATH

23 Jan 1966

3 P

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland, #212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland, Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Rural

D. STREET ADDRESS (If rural, give location)

145 Greenbank Road, #21220

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

2-5-1906

9. AGE (In years
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Sales-Lady

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George Miller

14. MOTHER'S MAIDEN NAME

Alda Hoffman

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

235-14-3875

17. INFORMANT

ADDRESS

RECORDS: BCH, 4940 Eastern Ave., #21224

18. 63X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Pneumonia

48 hr

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) Pulmonary metastatic ca of breast 3 yrs

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-21 19 66 to 1-23 19 66
that (I) (we) last saw the deceased alive on 1-23 19 66 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

1-23-66

23C. PHYSICIAN'S
NAME (Type)

Bruce Lee Evatt

M.D.

Baltimore City Hospital

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1/27/66

24C. NAME OF CEMETERY or CREMATORY

Woodlawn Memorial

24D. LOCATION

(City, town, or county)

(State)

Harrisburg, Pa.

25A. DATE REC'D BY HEALTH DEPT.

JAN 26 1966

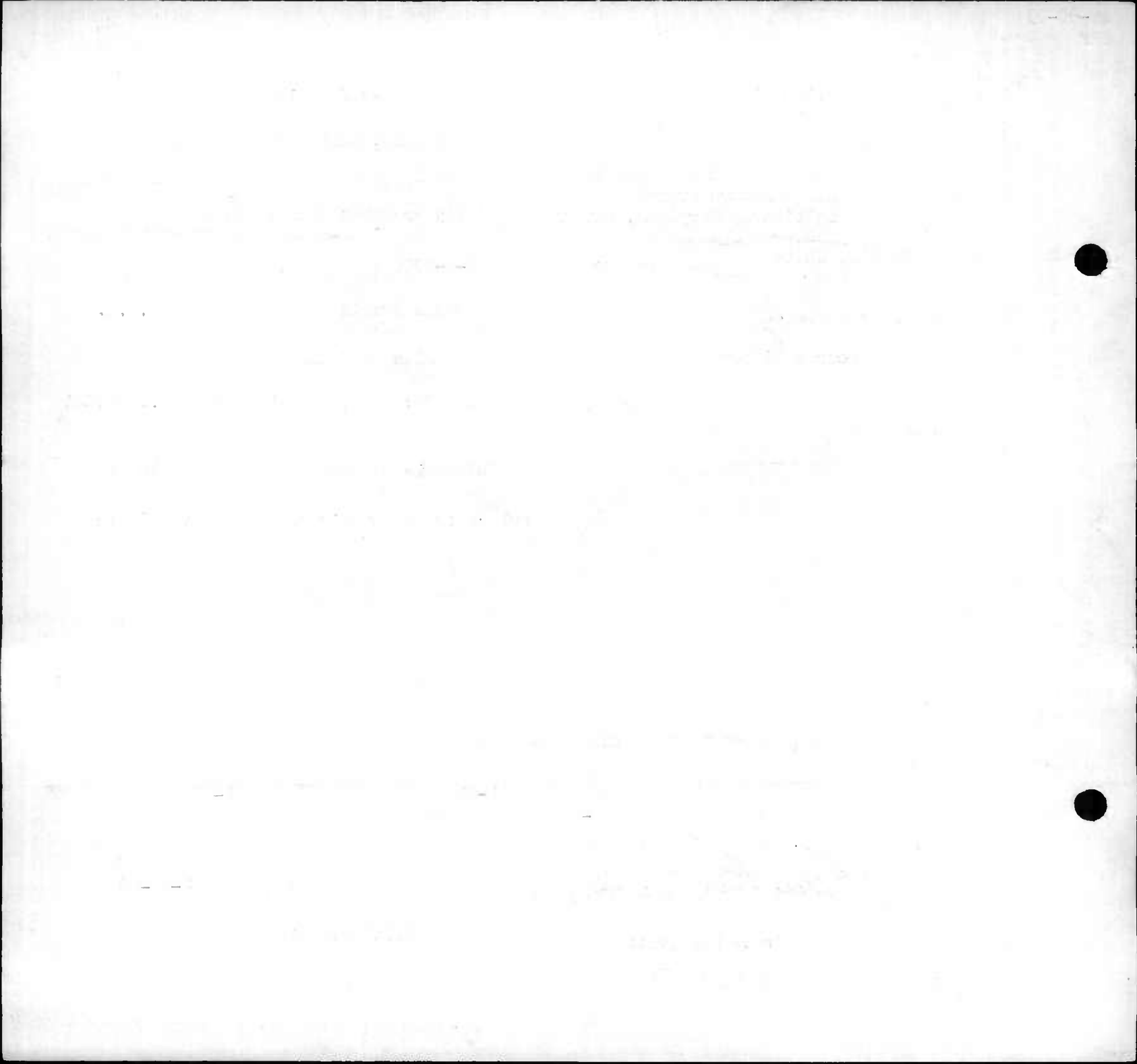
25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

ADDRESS

Connolly Sons 300 Mace Ave. Balt. 21



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <u>66 00857</u>				
61-06260 BIRTH NO. <u>66 00857</u> M.E. CASE NO. <u>66 00857</u>					2. DATE AND HOUR OF DEATH <u>1/23/66</u> <u>8 20</u> A. M.				
1. NAME OF DECEASED (Type or Print) <u>LEMUEL DAVIS</u>					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>15-12</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HD SPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>SINAI</u>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>3518 PARK HEIGHTS AVE</u>				
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <u>3/4/61</u>	9. AGE (In years last birthday) <u>4</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>ROBERT DAVIS</u>					14. MOTHER'S MAIDEN NAME <u>Klarthea Barksdale</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Klarthea Davis</u> ADDRESS <u>3518 Park Heights Baltimore Md</u>				
18. <u>340.31</u> CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					(A) <u>MENINGITIS (BACTERIAL)</u> DUE TO <u>4 DAYS</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) <u>HERNIATION OF MEDULLA</u> DUE TO <u>4 DAYS</u>				
(C) _____									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>2</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that <u>(H)</u> (this hospital) attended the deceased from <u>1/20</u> 19 <u>66</u> to <u>1/23</u> 19 <u>66</u> , that <u>(H)</u> (we) lost saw the deceased alive on <u>1/23</u> 19 <u>66</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(H)</u> (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Stanley Friedler</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1/23/66</u>		
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS M.D. <u>SINAI Hosp.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/26/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Corner Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Prince George County Md</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1966</u>		25B. NAME OF REGISTRAR <u>Ed E. Fisher</u>			25C. FUNERAL DIRECTOR <u>Elmer E. Bullard</u>		ADDRESS <u>725 E. North Ave Baltimore Md</u> <u>21202</u>		

Martin Black
in Martin Black

Black Martin
Black Martin

BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66-00858

1. NAME OF DECEASED
(Type or Print)

Ira Day SR.

2. DATE AND HOUR PRONOUNCED DEAD

1/22/66 8:15 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

Cecil

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Elkton

D. STREET ADDRESS (If rural, give location)

R.F.D. 4

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

JUNE 7, 1908

9. AGE (In years
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

LABORED

10B. KIND OF BUSINESS OR INDUSTRY

MOTORS

11. BIRTHPLACE (State or foreign country)

BRADSHAW, W.V.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

THOMAS J. DAY

14. MOTHER'S MAIDEN NAME

NO INFO

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

228-01-8802

17. INFORMANT

IRA DAY, JR.

ADDRESS

RD # 3

ELKTON, MD.

18.

E 976X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Gunshot wound of head

(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CAUSING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

R.F.D. 4 Elkton, Md.

21D. TIME OF INJURY (APPROX.)

1 22 66 2:40p. m.

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

shot self in head

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

1/23/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

1-27-66

23C. NAME OF CEMETERY or CREMATORY

DAY CEMETERY

23D. LOCATION (City, town, or county)

BRADSHAW, W.V.

24A. DATE REC'D BY HEALTH DEPT.

JAN 26 1966

24B. NAME OF REGISTRAR

Robert L. Farley, M.D.

24C. FUNERAL DIRECTOR

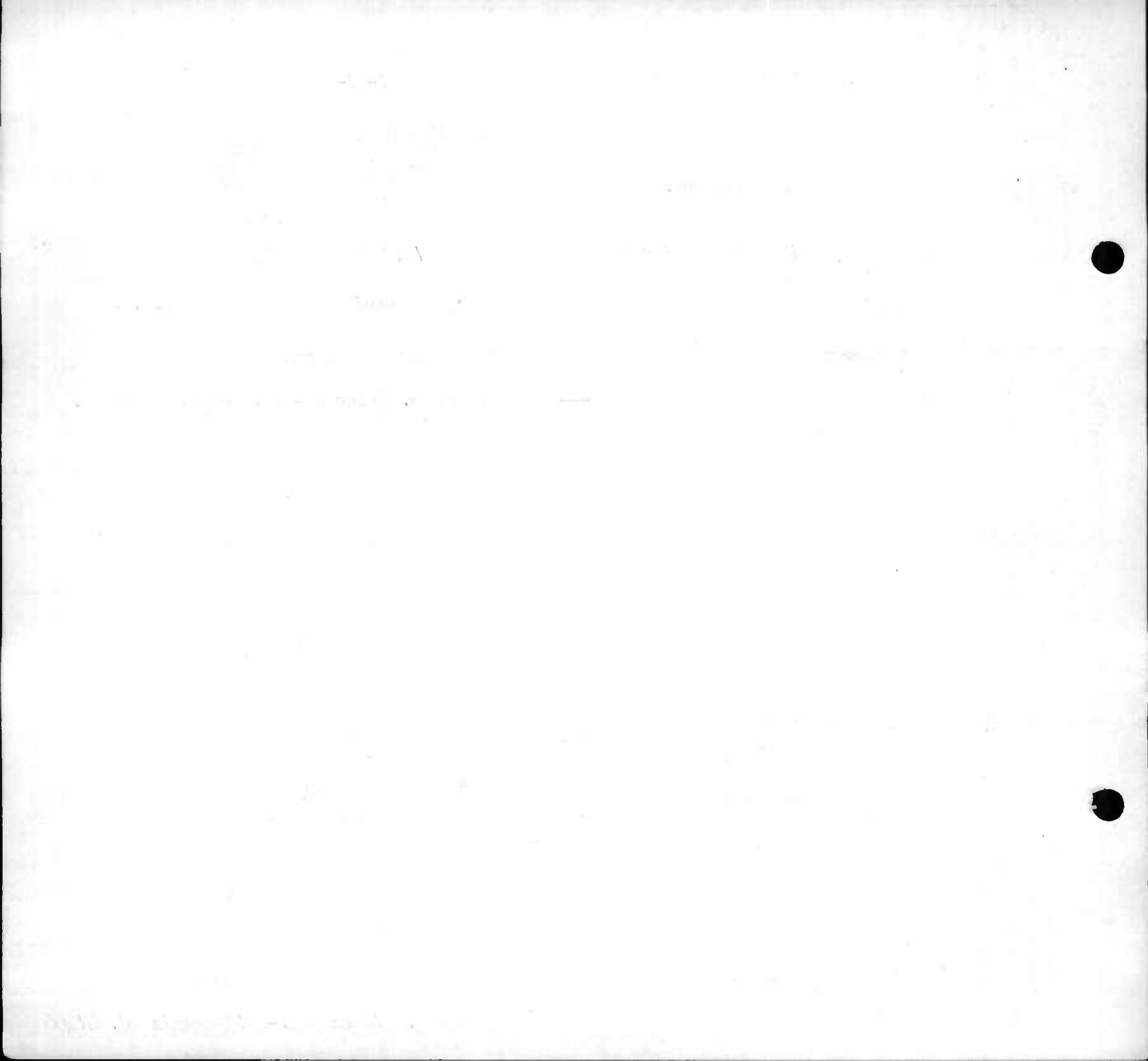
PIPPIN FUNERAL HOME ELKTON, MD.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

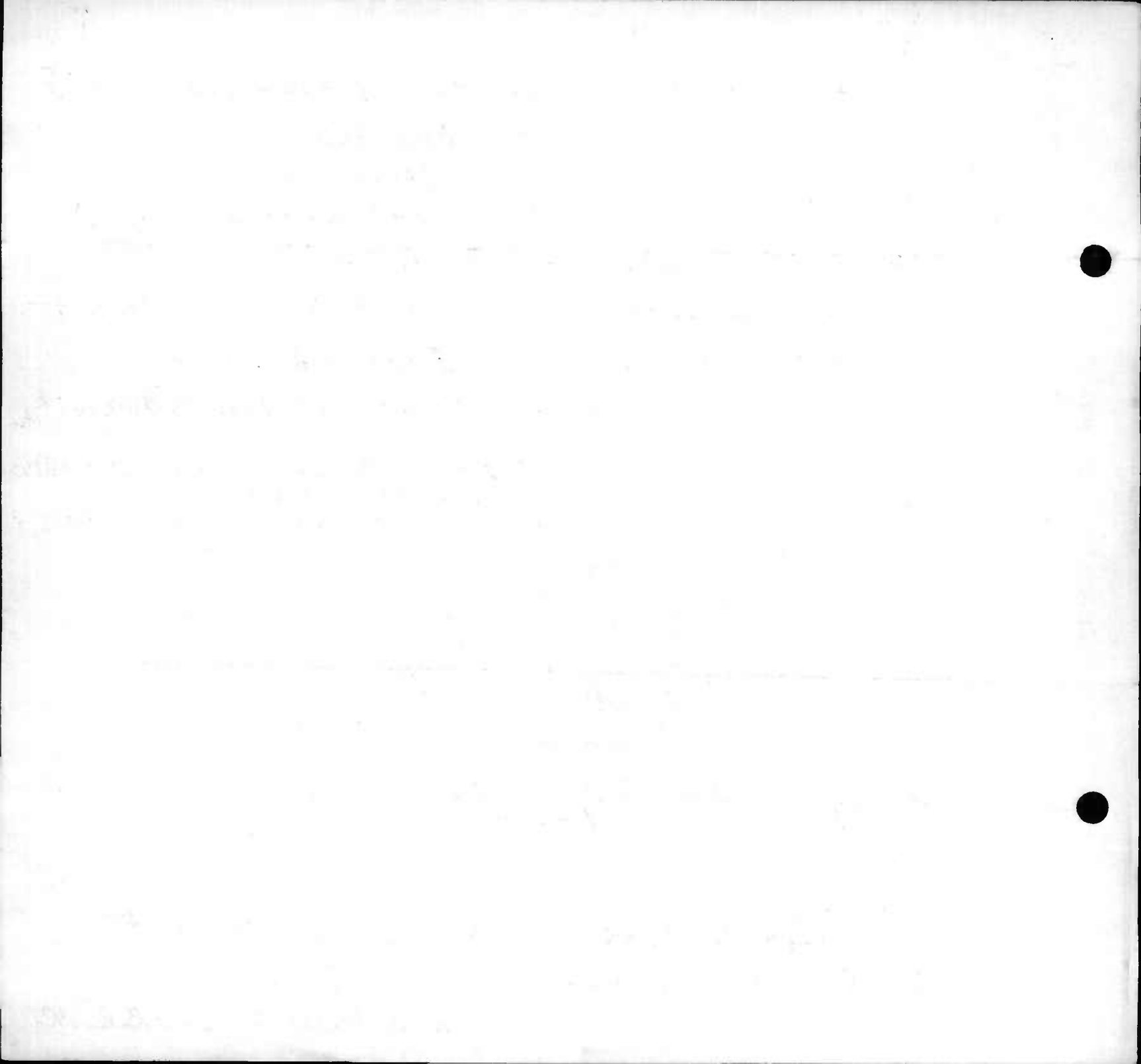
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00859	
BIRTH NO. 66 00859		CERTIFICATE OF DEATH		Registered No. 66 00859	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>A. Lillian Gunn</i>		2. DATE AND HOUR OF DEATH <i>1-21-66</i> <i>9 A.</i> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>3202 Lyndale Ave.</i>		A. STATE <i>Maryland</i> 8. COUNTY <i>8-01</i>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>3202 Lyndale Avenue</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED <i>Widowed</i>	8. DATE OF BIRTH <i>July 11, 1893</i>	9. AGE (In years last birthday) <i>72</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Nancy Kellner</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>---</i>		17. INFORMANT ADDRESS <i>Roland A. Gosnell - Rt. 2 - Mt. Airey Md.</i>	
18. <i>443 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <i>Arteriosclerotic hypertensive Cardio-Vascular Disease</i> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>19 yrs</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1-9-</i> <i>1947</i> to <i>1-15-</i> <i>1966</i> , that (I) (we) last saw the deceased alive on <i>1-15-</i> <i>1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <i>Milton C. Lang</i>				23B. DATE SIGNED <i>1-22-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Milton C. Lang</i>				23D. ADDRESS <i>2117 Belair Rd Balto Md 21223</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-24-66</i>		24C. NAME OF CEMETERY or CREMATORY <i>Western Cemetery</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 26 1966</i>		25B. NAME OF REGISTRAR <i>John G. Miller Inc.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>415 Belair Rd. 21206</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00860				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 00860	
1. NAME OF DECEASED (Type or Print) LARSEN Mrs. MARTHA A.				2. DATE AND HOUR OF DEATH 1-22-1966 2:15 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 8-02					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MONTEBELLO STATE HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE					
				D. STREET ADDRESS (If rural, give location) 1641 N. PATTERSON AVE.					
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH FEB. 4, 1897	9. AGE (In years last birthday) 68	10. Under 1 Yr. Months: Days: Hours: Min.		11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE (RETIRED)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME L. HERMAN, RIEDEL				14. MOTHER'S MAIDEN NAME FREDERICKA SCHARFE					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE		17. INFORMANT KARL A. LARSEN		ADDRESS 1641 N. PATTERSON PK. AVE	
18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) C.V.A. (multiple embolism) E (R) HEMIPARESIS (B) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE (C) YEARS					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12-9-1965 to 1-22-1966 , that (I) (we) last saw the deceased alive on 1-22-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Zin U. Park						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-22-1966	
23C. PHYSICIAN'S NAME (Type) ZIN U. PARK				23D. ADDRESS MONTEBELLO STATE HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/26/66		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem.		24D. LOCATION (City, town, or county) (State) Ba/to. Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1966				25B. NAME OF REGISTRAR John C. Melhu Inc.		25C. FUNERAL DIRECTOR John C. Melhu Inc.		ADDRESS -6415 Belair Rd.	



BIRTH NO. 66 00861 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 00861

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)HARRY
HARRY SHELTON ~~XXXXXX~~ L. SHELTON

2. DATE AND HOUR PRONOUNCED DEAD

January 21 1966 9.50 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

3524 Woodland Avenue

5. SEX

M

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

SEPARATED

8. DATE OF BIRTH

JANUARY 31, 1892

9. AGE (In years
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

GROCER

10B. KIND OF BUSINESS OR INDUSTRY

RETIRED

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

OTIS G. SHELTON

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

232-12-7517

17. INFORMANT

ADDRESS

MRS. DOROTHY M. PHIPPS, 4700 SAYER AVENUE #29

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular
disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Jan. 27/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

1/25/66

23C. NAME of CEMETERY or CREMATORY

WOODLAWN CEMETERY

23D. LOCATION

BALTIMORE,

(City, town, or county)

(State)

MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

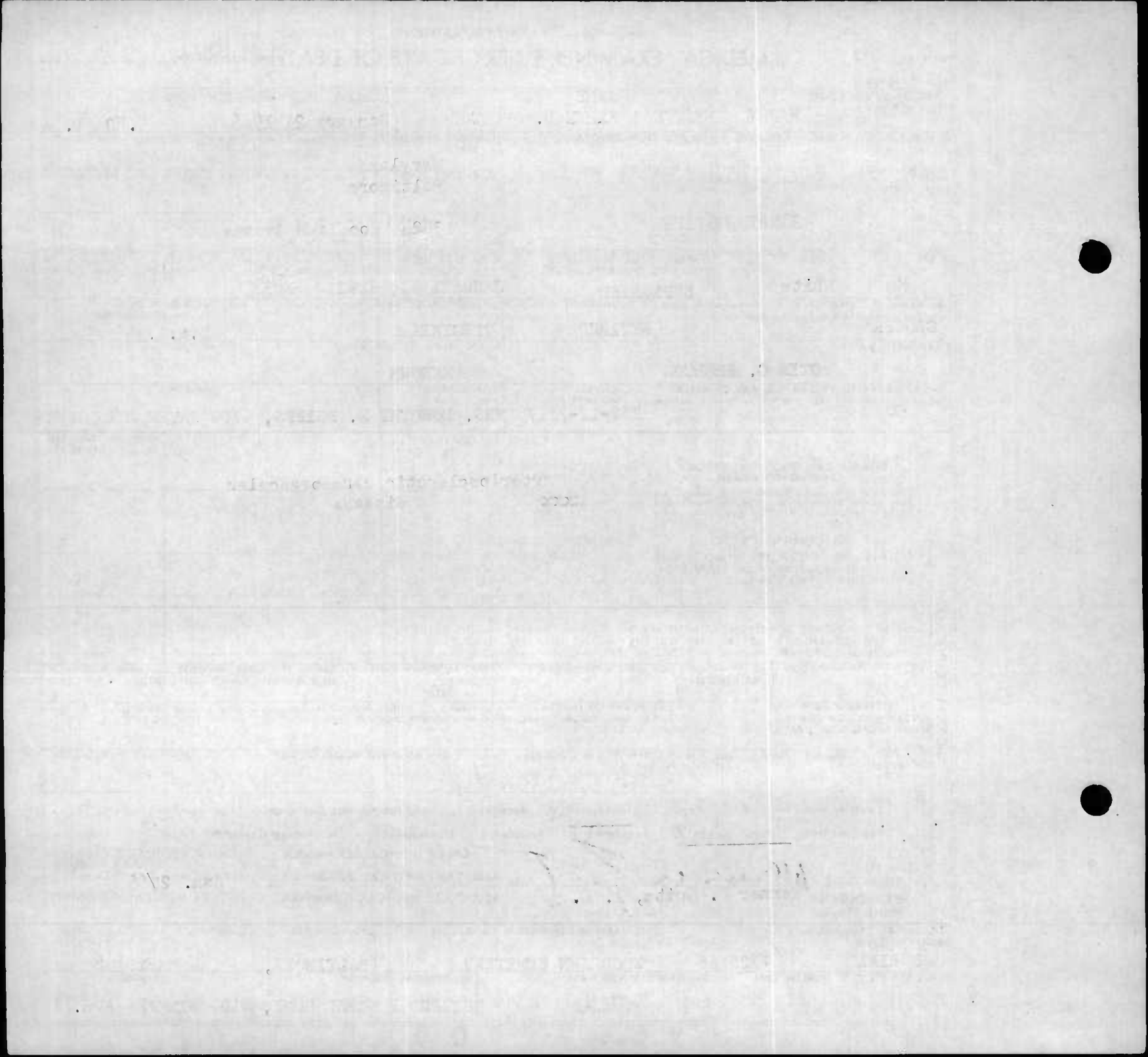
24C. FUNERAL DIRECTOR

ADDRESS

JAN 26 1966

Robert E. Fairbank

HUBBARD FUNERAL HOME, 4107 WILKENS AVE. # 29



CERTIFICATE OF DEATH

Registered No. 66 00862

BIRTH NO.

66 00862

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Harry J. Beatty

2. DATE AND HOUR OF DEATH

1-24-66

12:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6301 Elliott Street

21224

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

1-25-1882

9. AGE (In years
last birthday)

83

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Moulder-retired

10B. KIND OF BUSINESS OR INDUSTRY

Iron

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Millard F. Beatty

14. MOTHER'S MAIDEN NAME

Katherine Ryan

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue

21224

18.

4-20-11

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Coronary arrest

INTERVAL BETWEEN
ONSET AND DEATH

5 min

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) DUE TO

? MI

~15 min

(C) DUE TO

ASCVD

20 years

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from

1-23

19 66 to

1-24

19 66.

that (I) (we) last saw the deceased alive on

1-24

19 66

and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Brian B. Bouton

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

1-24-66

23C. PHYSICIAN'S
NAME (Type)

BRIAN B. BOUTON

M.D.

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1/27/66

24C. NAME OF CEMETERY or CREMATORY

Parkwood Cemetery

24D. LOCATION

(City, town, or county)

Parkville, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 26 1966

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Ulrich Funeral Home 4210 Belair Road.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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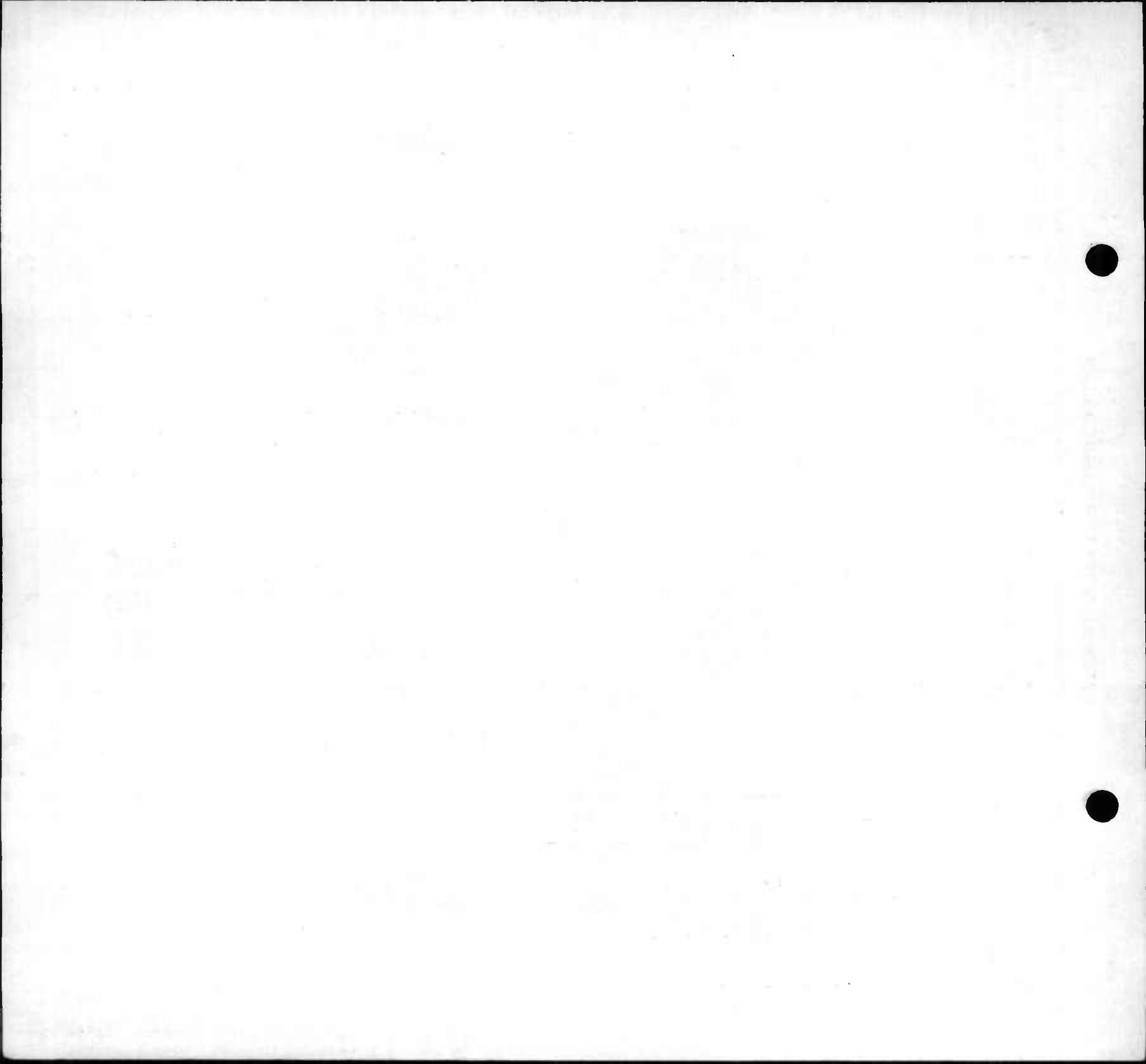
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00863	
BIRTH NO. 66 00863		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Isabel C. Hurd		2. DATE AND HOUR OF DEATH January 24, 1966 6 A.M. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		7-02	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 513 N. Lakewood Ave.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 513 N. Lakewood Ave.	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Jan. 29, 1884	9. AGE (In years last birthday) 81	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Magaw		14. MOTHER'S MAIDEN NAME Wilhelmina	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Harry P. Hurd, Sr., 513 N. Lakewood Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 170X I Tonic Absorption		CAUSE OF DEATH (A) DUE TO (B) DUE TO Carcinoma of Left Breast (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 4 hours 2 years	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (the hospital) attended the deceased from March 1964 to January 24, 1966, that (I) (we) last saw the deceased alive on January 24, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Michael J. Dausch		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED January 24, 1966	
23C. PHYSICIAN'S NAME (Type) Michael J. Dausch		23D. ADDRESS 4636 Belair Road			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1.26/66		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State) Parkville, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 26 1966		25B. NAME OF REGISTRAR T. J. Taylor, M.D.	
25C. FUNERAL DIRECTOR Ullrich Funeral Home 4210 Belair Road.		25D. ADDRESS			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T 252 1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 66 00864

BIRTH NO. 66 00864

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Catherine Justus Tysinger

2. DATE AND HOUR OF DEATH

Jan. 25, 1966

2:15 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

US Public Health Service Hospital
Wyman Pk. Drive & 31st Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)
Jessup

D. STREET ADDRESS (If rural, give location)
16 Dorsey Run Road

5. SEX

F

6. RACE

W

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Wid.

8. DATE OF BIRTH

7/23/09

9. AGE (In years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

James B. Matthews

14. MOTHER'S MAIDEN NAME

Emma Justus

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

238-14-5950

17. INFORMANT

ADDRESS

Records- US PHS Hospital, Balto, Md.

18. 170X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Cancer of the breast with

INTERVAL BETWEEN
ONSET AND DEATH

8 yrs.

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO metastasis

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Status post left mastectomy
Status post hypophysectomy

8 yrs

2 yrs

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from July 12 1965 to Jan. 25 1966,
that (1) (we) last saw the deceased alive on Jan. 25 1966 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (1) (We) (did) (not) view the body after death.

23A. SIGNATURE

Alvin Stein

M.D.

Attending
Phys. ☐

Med.
Director ☐

Staff
Phys. ☒

23B. DATE SIGNED

1/25/66

23C. PHYSICIAN'S
NAME (Type)

Alvin Stein, Surgeon

23D. ADDRESS

M.D.

US PHS Hospital, Balto, Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1/21/66

24C. NAME of CEMETERY or CREMATORY

Greenlawn Memorial Cemetery

24D. LOCATION

(City, town, or county)

(State)

Wilmington, N.C.

25A. DATE REC'D BY HEALTH DEPT.

JAN 26 1966

25B. NAME OF REGISTRAR

Alvin Stein

25C. FUNERAL DIRECTOR

ADDRESS

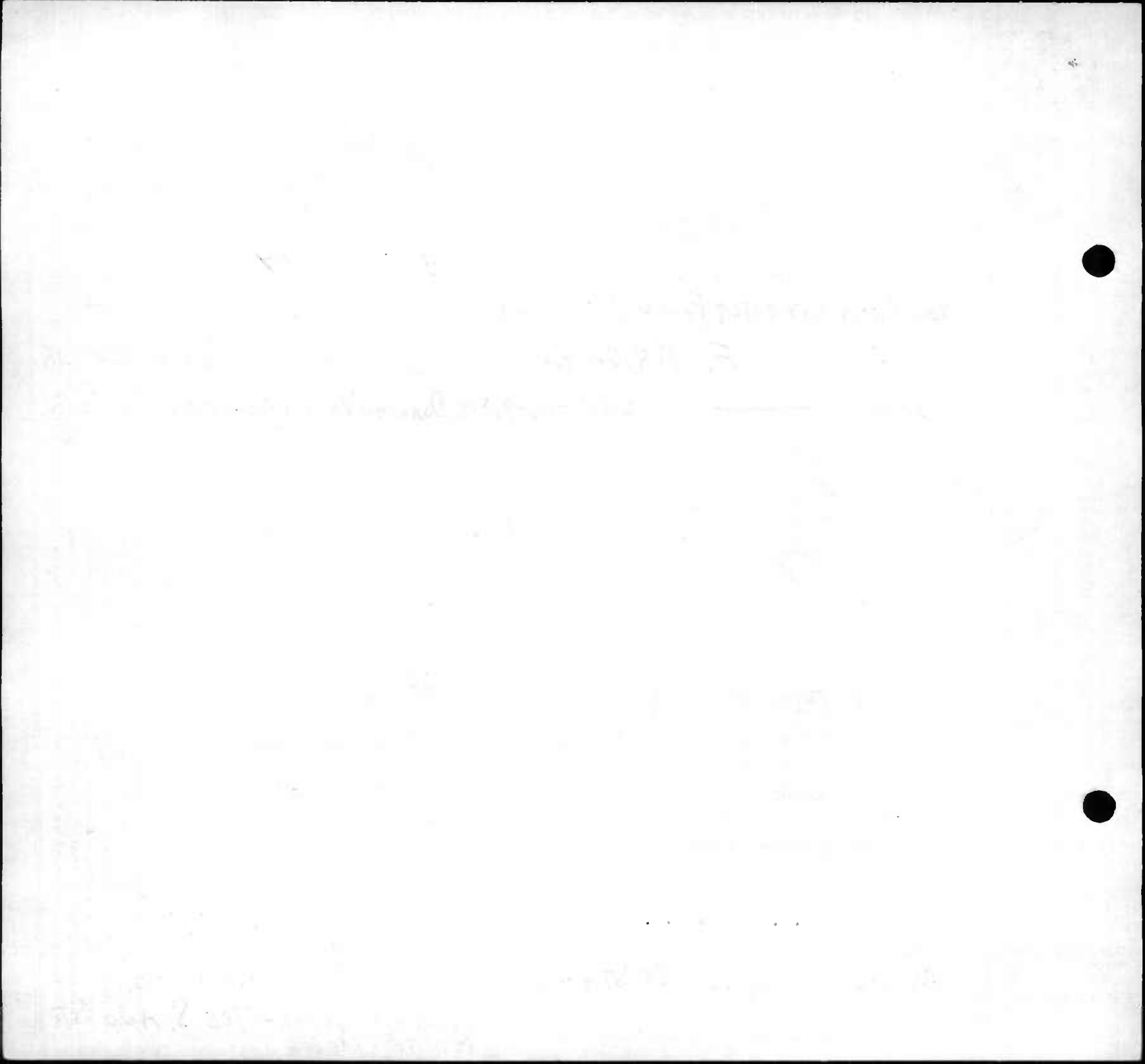
Ullrich Funeral Home 4210 Belair Road.

John B. Allen

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
66 00865 M. CERTIFICATE OF DEATH					Registered No. 66 00865									
BIRTH NO.		M.E. CASE NO.			1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
					Bernard Krisman					1-25-66 8:15 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)										A. STATE B. COUNTY				
South Baltimore General Hosp.										Maryland 1-02				
C. CITY OR TOWN (If outside city limits, write RURAL and give township)										Baltimore #21224				
D. STREET ADDRESS (If rural, give location)										2909 Eastern AVE.				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)			8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.					
M	White	Married			8-15-10	54								
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country)				
TOOL CRIB OPERATOR					FAWN PLASTICS CO.					Baltimore, Md.				
12. CITIZEN OF WHAT COUNTRY?					13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
U.S.A.					Michael F. KRISMAN					Catherine LUKASZEWSKI				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS				
NO					218-05-0649					MRS DOROTHY VALANCIUS - 1106 CRENS RD.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH										CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)										(A) DUE TO myocardial infection				
ANTECEDENT CAUSES										(B) DUE TO pulmonary embolism				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(C)				
II														
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)				
										No				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that the (this hospital) attended the deceased from 12-31 1965 to 1-25 1966, that we (we) last saw the deceased alive on 1-25 1966 and that in the (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE										23B. DATE SIGNED				
C.C. Palad, M.D.										1-25-66				
23C. PHYSICIAN'S NAME (Type)										23D. ADDRESS				
C.C. PALAD, Jr.										South Baltimore General Hospital, S.B.G.H., 1213 Light ST.				
24A. BURIAL CREMATION, REMOVAL (Specify)					24B. DATE					24C. NAME OF CEMETERY or CREMATORY				
BURIAL					1/28/66					ST. STANISLAUS				
25A. DATE REC'D BY HEALTH DEPT.					25B. NAME OF REGISTRAR					25C. FUNERAL DIRECTOR ADDRESS				
JAN 26 1966					G. A. Weber					GEORGE A. WEBER - 705 S. ANN ST. PER TED WEBER				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00866	
BIRTH NO. 66 00866		CERTIFICATE OF DEATH		X	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MR. BUERHAUS EDWARD M.		2. DATE AND HOUR OF DEATH 1-23-1966 at 9-45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland, B. COUNTY Harford		C. CITY OR TOWN (If outside city limits, write RURAL and give township) HAVRE DE GRACE 62-00	
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL BALTIMORE MD 21218		D. STREET ADDRESS (If rural, give location) Route #2			
5. SEX Male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 10-13-96	9. AGE (In years last birthday) 69	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer (Ret.)		10B. KIND OF BUSINESS OR INDUSTRY Commercial Cr. Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CHARLES BUERHAUS		14. MOTHER'S MAIDEN NAME unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW*1 (Navy)		16. SOCIAL SECURITY NO. 214-22-6481		17. INFORMANT MRS IDA E. BUERHAUS wife	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 260X1		CAUSE OF DEATH (A) DUE TO Congestive Cardiac failure (B) DUE TO Diabetes Mellitus (C) DUE TO Amputation Lt. Leg.		INTERVAL BETWEEN ONSET AND DEATH difficult to determine	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 1-20-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Congestive heart failure		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-30-1965 to 1-23-1966 , that (I) (we) last saw the deceased alive on 1-23-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE F. Martin		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/23/66	
23C. PHYSICIAN'S NAME (Type) FELIX J. MARTIN		23D. ADDRESS Union Memorial Hosp., Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-26-66		24C. NAME OF CEMETERY or CREMATORY Rock Run Cemetery	
24D. LOCATION (City, town, or county) (State) R.D. Havre de Grace, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 26 1966			
25B. NAME OF REGISTRAR John E. Taylor		25C. FUNERAL DIRECTOR John E. Taylor			

[Faint handwritten signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00867				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 00867	
1. NAME OF DECEASED (Type or Print) WILLIAM H. HARRIS				2. DATE AND HOUR OF DEATH 1-23-1966					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1725 N. Spring Street				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 9-09 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1725 N. Spring Street					
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 11-11-1898		9. AGE (In years last birthday) 67		10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick layer			10B. KIND OF BUSINESS OR INDUSTRY Brick Layer			11. BIRTHPLACE (State or foreign country) Richmond, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac H. Harris				14. MOTHER'S MAIDEN NAME Martha Modden					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT 1725 N. Spring St. ADDRESS Mrs. Rose Ella Harris			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 420-01 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				19. CAUSE OF DEATH Arterio-sclerotic Heart Disease				INTERVAL BETWEEN ONSET AND DEATH ?	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) No.		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 12/22 19 65 to 1/23 19 66 . that (I) (we) last saw the deceased alive on 12/22 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Bernard Harris Sr				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/24/66			
23C. PHYSICIAN'S NAME (Type) Bernard Harris Sr				23D. ADDRESS 1202 N Caroline St.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-28-66		24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1966		25B. NAME OF REGISTRAR Marshall W. Jones, Jr.		25C. FUNERAL DIRECTOR 1735 Harford Ave. ADDRESS					

Return - Robert - 1900



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The body of Dwight Smallwood was released to The Johns Hopkins Hospital on approval by Dr. Gram of the Medical Examiners Office

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00868		CITY HEALTH DEPARTMENT		Registered No. 66 00868	
M.E. CASE NO.		CERTIFICATE OF DEATH		7:30 AM - 1/24/66	
1. NAME OF DECEASED (Type or Print) Dwight E. Smallwood		2. DATE AND HOUR OF DEATH		M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Maryland		8-05	
The Johns Hopkins Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
		D. STREET ADDRESS (If rural, give location)		1831 North Wolfe Street	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 3 2 1948	9. AGE (In years last birthday) 17	10. CITIZEN OF WHAT COUNTRY? U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Annapolis, Maryland	
13. FATHER'S NAME Davis Smallwood		14. MOTHER'S MAIDEN NAME Queenie Smallwood Reynolds		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 210-22-2418		17. INFORMANT ADDRESS 1831 N. Wolfe St. Mrs. Queenie Reynolds	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Pulmonary Edema Fever of unknown origin	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		21. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 10 min. 7 hrs.	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work Not While At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/24-3 AM 1966 to 1/24 7:30 AM 1966 that (I) (we) last saw the deceased alive on 1/24/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE E. Eugene Page M.D.		23B. DATE SIGNED 1/24/66	
23C. PHYSICIAN'S NAME (Type) E. Eugene Page		23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-27-1966		24C. NAME OF CEMETERY OR CREMATORY Baltimore National	
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. NAME OF REGISTRAR Marshall W. Jones, Jr.		24F. FUNERAL DIRECTOR 1735 Harford Av. ADDRESS	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1966		25B. NAME OF REGISTRAR Marshall W. Jones, Jr.		25C. FUNERAL DIRECTOR 1735 Harford Av. ADDRESS	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																								
66 00869					CERTIFICATE OF DEATH					Registered No. 66 00869														
BIRTH NO.										M.E. CASE NO.														
1. NAME OF DECEASED (Type or Print) <i>Weidner, Edward J.</i>										2. DATE AND HOUR OF DEATH <i>9⁵⁰ PM 1/28/66</i>														
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>Church Home & Hosp</i>										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>7-02</i>														
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)										C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>														
										D. STREET ADDRESS (If rural, give location) <i>611 N. Rose St.</i>														
5. SEX <i>M</i>		6. RACE <i>Cauc</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>M</i>		8. DATE OF BIRTH <i>2/4/15</i>		9. AGE (In years last birthday) <i>50</i>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.												
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Butcher</i>					10B. KIND OF BUSINESS OR INDUSTRY <i>Edgewood Arsenal</i>					11. BIRTHPLACE (State or foreign country) <i>Maryland</i>					12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>									
13. FATHER'S NAME <i>George Weidner</i>										14. MOTHER'S MAIDEN NAME <i>Danneman</i>														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes WW 2 - Army</i>										16. SOCIAL SECURITY NO. <i>213-01-3835</i>					17. INFORMANT <i>chart</i>					ADDRESS				
18. <i>581.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>Bleeding Esophageal Varices</i>										CAUSE OF DEATH (A) DUE TO <i>Lower Esophagus</i>										INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Portal Hypertension</i>										(B) DUE TO										(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																								
19A. DATE OF OPERATION <i>3/1/20/66</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Esophageal Bleeding</i>					20A. AUTOPSY? (Yes or No) <i>YES</i>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)														
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?														
22. I certify that (I) (this hospital) attended the deceased from <i>December 31 1965</i> to <i>January 24 1966</i> , that (I) (we) last saw the deceased alive on <i>January 24 1966</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																								
23A. SIGNATURE <i>Jose Y. Ortiz M.D.</i>										Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <i>1-28-66</i>									
23C. PHYSICIAN'S NAME (Type) <i>Jose Y. Ortiz</i>										23D. ADDRESS M.D.														
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>					24B. DATE <i>1/28/66</i>					24C. NAME OF CEMETERY or CREMATORY <i>Sacred Heart Cemetery</i>					24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>									
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 26 1966</i>					25B. NAME OF REGISTRAR <i>Edgewood Arsenal</i>					25C. FUNERAL DIRECTOR <i>Schimunek Funeral Home, Inc.</i>					ADDRESS <i>26601 E. Madison St.</i>									

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 00870		CERTIFICATE OF DEATH				Registered No. 66 00870			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) AUGUST THOMAS JANDA				2. DATE AND HOUR OF DEATH Jan. 23, 1966 5 a. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 520 N. Streeper St. Baltimore, Md., 21205					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 520 N. Streeper St.				
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 10/28/1898	9. AGE (In years last birthday) 67	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret-Civil Ser. Examiner		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME unknown					14. MOTHER'S MAIDEN NAME unknown				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes Marines WW 1--22			16. SOCIAL SECURITY NO. 12-36-9994		17. INFORMANT Rose Sponsal Janda, wife, above				
18. 241 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) BRONCHIAL ASTHMA DUE TO (B) DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH 2-3 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1955 to 1-23-1966, that (I) (we) last saw the deceased alive on 1-22-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Dr. Benjamin Moses, M.D.					23B. DATE SIGNED 1/25/66			23C. PHYSICIAN'S NAME (Type) Dr. Benjamin Moses	
23D. ADDRESS 448 N. Luzerne Ave.									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/26/66		24C. NAME OF CEMETERY or CREMATORY Balto. Nat. Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1966		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 2601 E. Madison St.			ADDRESS		

Benjamin Franklin

George Washington

1776

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				66 00871	
BIRTH NO.				66 00871	
M.E. CASE NO.				66 00871	
1. NAME OF DECEASED (Type or Print) <i>Ludmila or Lily</i> <i>Mrs. LILLY MYNAR</i>			2. DATE AND HOUR OF DEATH <i>1-23-66</i> <i>3:10 P.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>35 Church Home & Hospital</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>7-02</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>2540 Ashland Ave</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED; NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>12-30-93</i>	9. AGE (In years last birthday) <i>72</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H-Wife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Czechoslovakia</i>	
13. FATHER'S NAME <i>Frank Stepanek</i>			14. MOTHER'S MAIDEN NAME <i>Anna Havlenova</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>216-03-5662</i>		17. INFORMANT <i>James Mynar, husband</i> ADDRESS <i>Chart above</i>	
18. <i>201X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <i>CHF & pulm. edema</i> DUE TO <i>Anemia</i> (B) <i>Hodgkins disease</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>days</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>D</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1-13</i> 19 <i>66</i> to <i>1-23</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>1-23</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>A. E. Saborsky M.D.</i>				23B. DATE SIGNED <i>1-23-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr. A. E. Saborsky, M.D.</i>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/27/66</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Bohemian National Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 26 1966</i>			
25B. NAME OF REGISTRAR <i>Dr. A. E. Saborsky</i>		25C. FUNERAL DIRECTOR <i>Schimunek Funeral Home, Inc.</i>			
25D. ADDRESS <i>2601 E. Madison St.</i>					

Received
of the sum of
\$500.00

1900

George Washington

Check

For a year's salary

to

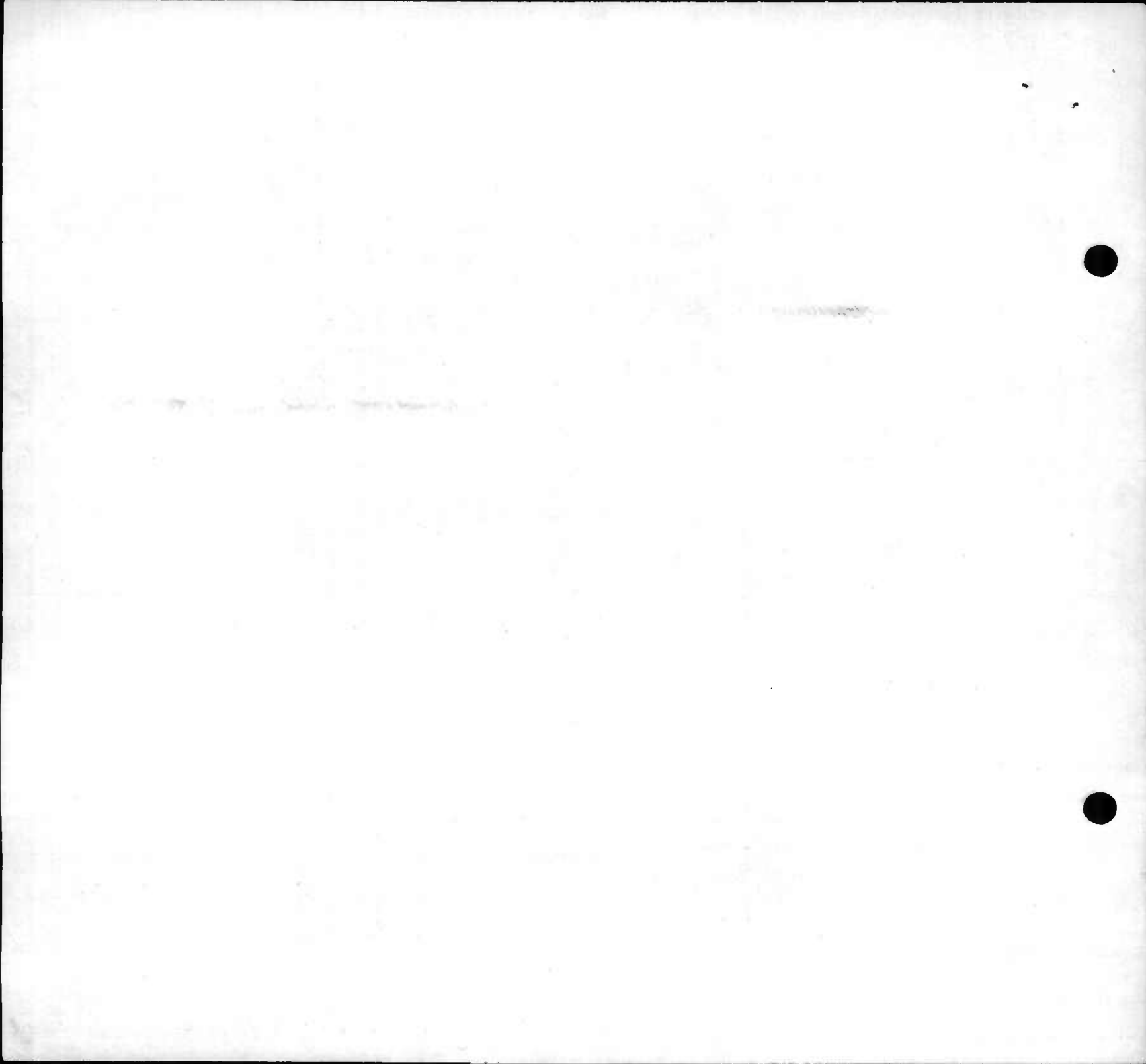
George Washington

Wm. A. G. Campbell
1900

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 66 00872					CERTIFICATE OF DEATH					Registered No. 66 00872				
1. NAME OF DECEASED (Type or Print) <u>Goodman, Irvin</u>					2. DATE AND HOUR OF DEATH <u>1-24-66</u> <u>1:30</u> P.M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>SANAI HOSPITAL OF BALTO</u>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>7032 Wallis Ave #15</u>									
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. <input checked="" type="checkbox"/> MARRIED, NEVER MARRIED <input type="checkbox"/> WIDOWED, <input type="checkbox"/> DIVORCED (specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>6/4/02</u>		9. AGE (In years last birthday) <u>63</u>		If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SELF-EMPLOYED</u>					10B. KIND OF BUSINESS OR INDUSTRY <u>DRIVE-IN Restaurant</u>					11. BIRTHPLACE (State or foreign country) <u>Balto. Md</u>				
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					13. FATHER'S NAME <u>Henry Goodman</u>					14. MOTHER'S MAIDEN NAME <u>Anna Marek</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS <u>MRS. Esther Goodman 7032 Wallis Ave</u>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>420.11</u> <u>Acute myocardial infarct</u> <u>ASCVD</u>					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)					INTERVAL BETWEEN ONSET AND DEATH <u>?</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Renal disease</u>														
19A. DATE OF OPERATION <u>none</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>none</u>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>1/22/66</u> to <u>1-24-66</u> that (I) (we) last saw the deceased alive on <u>1-24-66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <u>Harry M. Walen</u>										23B. DATE SIGNED <u>1-24-66</u>				
23C. PHYSICIAN'S NAME (Type) <u>HARRY M. WALEN</u>										23D. ADDRESS <u>5356 Carriage Ct. Balto 21229</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					24B. DATE <u>1/25/66</u>					24C. NAME OF CEMETERY or CREMATORY <u>Beth Eliah</u>				
24D. LOCATION <u>Balto Maryland</u>					24E. (City, town, or county) (State)									
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1966</u>					25B. NAME OF REGISTRAR <u>John E. Fisher</u>					25C. FUNERAL DIRECTOR ADDRESS <u>John E. Fisher & Sons Inc 6010 Reisterstown Rd</u>				



BIRTH NO.

66 00872

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 00873

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MILTON SAVAGE

2. DATE AND HOUR PRONOUNCED DEAD

1-24-66

1:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

6116 PARK HEIGHTS AVENUE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6116 Park Heights Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

NEVER MARRIED

8. DATE OF BIRTH

JUNE 4, 1897

9. AGE (In years
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

EMPLOYEE

10B. KIND OF BUSINESS OR INDUSTRY

BOND BAKERY CO

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

ABEL JACOB SAVAGE

14. MOTHER'S MAIDEN NAME

JULIE ZELKOWITZ

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

215-10-5099

17. INFORMANT

ADDRESS

MRS. DORA SAVAGE 6011 WALLIS AVENUE

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-24-66

23A. BURIAL CREMATION,
REMOVAL (specify)

BURIAL

23B. DATE

1/26/66

23C. NAME of CEMETERY or CREMATORY

BNAI ISRAEL

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE, MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

JAN 26 1966

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD

ADDRESS

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 1-11-01 BY 60322 UCBAW/STP

11-10-01 11-10-01 11-10-01 11-10-01 11-10-01

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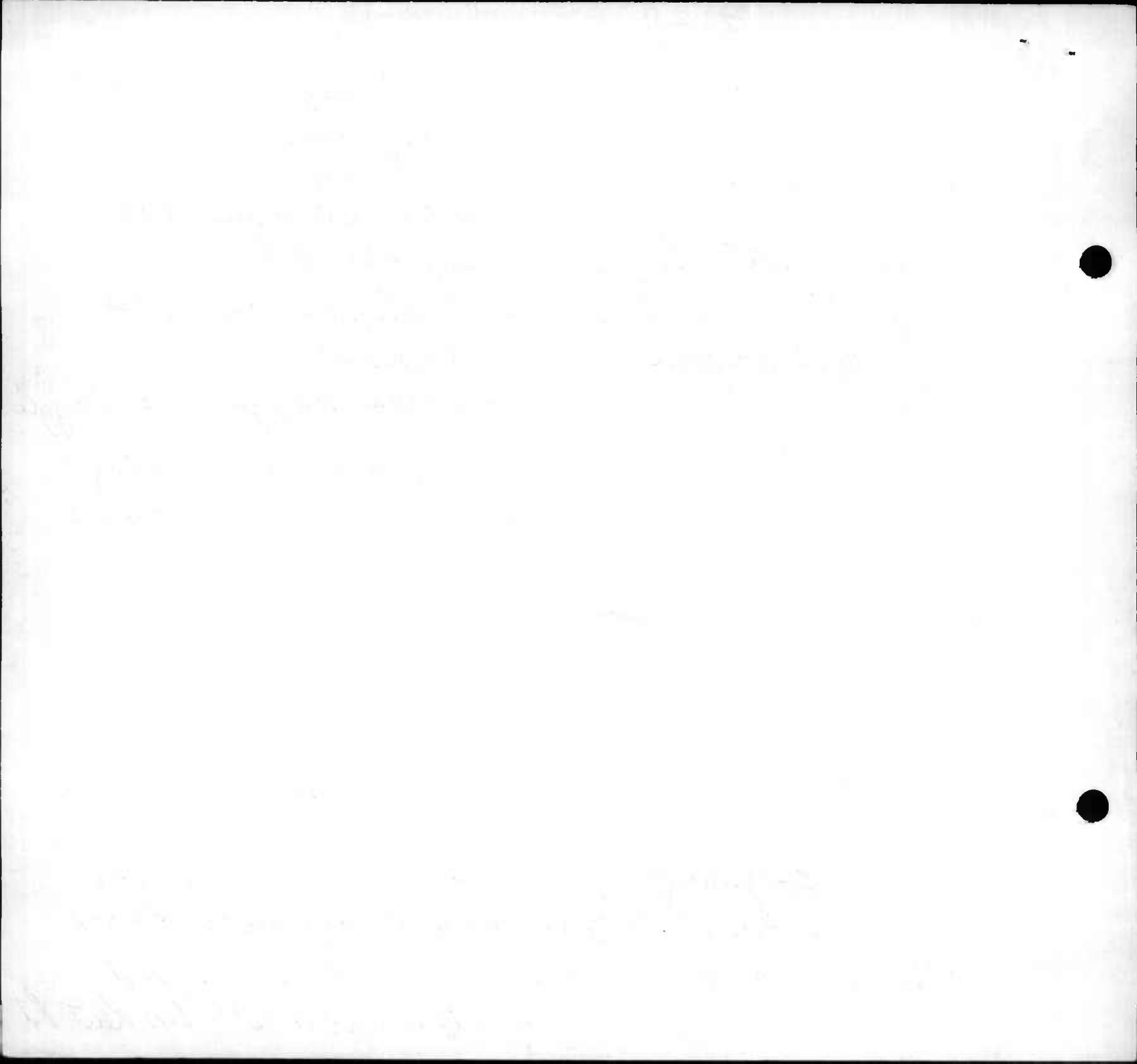
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 00874 CERTIFICATE OF DEATH					Registered No. 66 00874				
BIRTH NO. 66 00874					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) SOL KAUFMAN					2. DATE AND HOUR OF DEATH JANUARY 22, 1966 2:30 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3415 Clarks Lane					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-20 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3415 Clarks Lane				
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 9/19/1897	9. AGE (In years last birthday) 68	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wholesale		10B. KIND OF BUSINESS OR INDUSTRY Childrens Wear		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Philip Kaufman					14. MOTHER'S MAIDEN NAME Leah ?				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW 1 ARMY			16. SOCIAL SECURITY NO. 220-32-3131		17. INFORMANT ADDRESS Mrs. Beatrice Kaufman 3415 Clarks Lane #15				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 332 X 21 260 X Cerebral Thrombosis					INTERVAL BETWEEN ONSET AND DEATH 7 days				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebral Arteriosclerosis					4 yrs.				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Digheles Mellitus					12 yrs.				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from April 15 1954 to Jan 22 1966 , that (I) was last saw the deceased alive on Jan 21 1966 and that in my our opinion death occurred on the date and hour and from the causes stated above. (I) was did did not view the body after death.									
23A. SIGNATURE Albert J. Himelfarb M.D.					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/22/66		
23C. PHYSICIAN'S NAME (Type) ALBERT J. HIMELFARB M.D.					23D. ADDRESS 3501 ST PAUL ST BALTIMORE				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/23/1966		24C. NAME OF CEMETERY or CREMATORY Chizuk Amuno		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1966		25B. NAME OF REGISTRAR Albert J. Himelfarb		25C. FUNERAL DIRECTOR Sol Levinson & Bros.		ADDRESS 6010 Reisterstown Rd.			

FUNERAL DIRECTOR: IMPORTANT

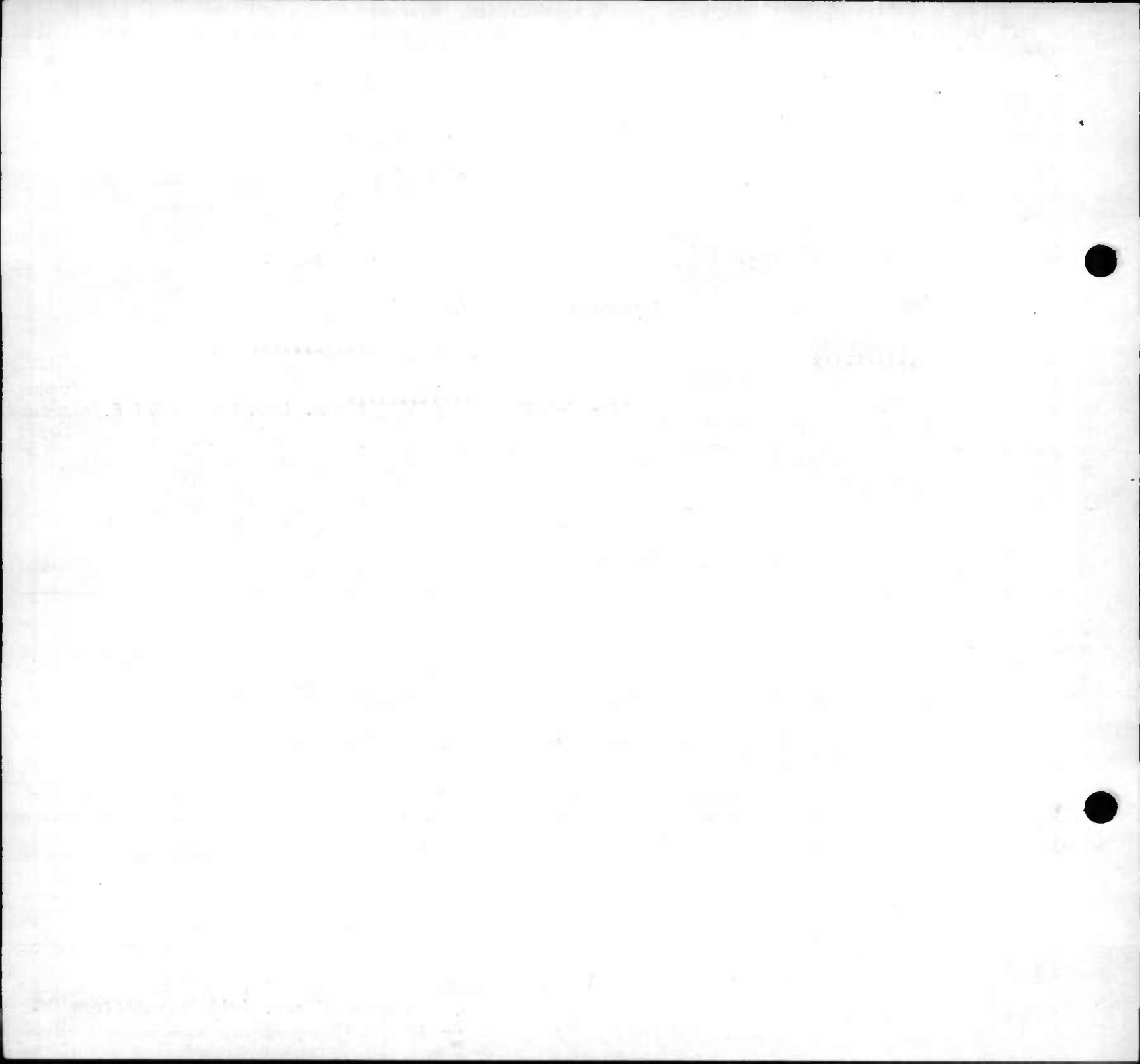
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00875				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00875	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Albert L. Margoles				January 23 / 66 3 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Sinai Hospital				Maryland 27-20			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				3906 Gleggyle Ave			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
Male	White	Single	March 24/1906	59			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Agent			Insurance		Baltimore, Md.		USA
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Harry Margolis				Anna			
15. Was Deceased ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
No						Mrs Reba Einziger - 3906 Gleggyle Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO		1 day	
ANTECEDENT CAUSES				(B) DUE TO		7 years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
10							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 7/25 1955 to 1/23 1966, that (I) (we) last saw the deceased alive on 12/27 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS		1/24/66	
ISRAEL ZINBERG				4000 W. NORTHERN PKWY			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		1/25/66		Workmen Circle		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 26 1966		Sol Levinson		Sol Levinson		6010 Kent Rd	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00876				CITY OF BALTIMORE DEPARTMENT OF HEALTH		Registered No. 66 00876	
1. NAME OF DECEASED (Type or Print) SAHUEL TRUSH				2. DATE AND HOUR OF DEATH 1-22-66 8:55 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 Church Home & Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 6-03 D. STREET ADDRESS (If rural, give location) 2321 E. Fairmount Ave			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12-12-05	9. AGE (In years last birthday) 60	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agent		10B. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Howard Trush				14. MOTHER'S MAIDEN NAME Lena Friedman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-07-2972		17. INFORMANT ADDRESS Mrs. Lena Trush 2321 E. Fairmount Avenue			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction - hours				INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White <input type="checkbox"/> Work At <input type="checkbox"/> Work At <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1-21 19 66 to 1-22 19 66 , that (I) (we) lost saw the deceased alive on 1-22 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature]				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) A. E. Subong, Jr.				23D. ADDRESS Church Home & Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/24/1966		24C. NAME OF CEMETERY or CREMATORY Anshe Emunah Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1966		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR ADDRESS Sol Levinson & Bros. 6010 Reisterstown Rd.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		M.E. CASE NO.		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No.	
66 00877		66 00877						66 00877	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH					
Kay R. Silber				1-23-66 2:20 PM					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY					
Sinai Hospital of Baltimore				Maryland U.S.A. Balto					
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				D. STREET ADDRESS (If rural, give location)					
Baltimore 5300				7942 Stevenson Rd. #8					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
Female	White	married	2/7/20	45					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife			At Home			Petersburg, W. Virginia		C.S.A.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
Benjamin Rubin			Rose Yateman			16. SOCIAL SECURITY NO.			
						17. INFORMANT ADDRESS			
						Mr. Samuel L. Silber 7942 Stevenson Road			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
(A) DUE TO				Hepatic failure					
(B) DUE TO				Carcinomatous					
(C) DUE TO				CA @ breast					
19. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)	
1-11-66				Carcinomatous				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?	
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (this hospital) attended the deceased from 1-9-66 to 1-23-66, that (I) (we) last saw the deceased alive on 1-23-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
Chare Phouprasert				1-23-66					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
CHARE PHON PRASERT				Sinai Hospital of Balto.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		1/24/1966		Beth El Memorial Park		Randallstown, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS			
JAN 26 1966		Robert E. Taylor		Sol Levinson & Bros.		6010 Reisterstown Road			

PRIOR TO
BALTIMORE CITY

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

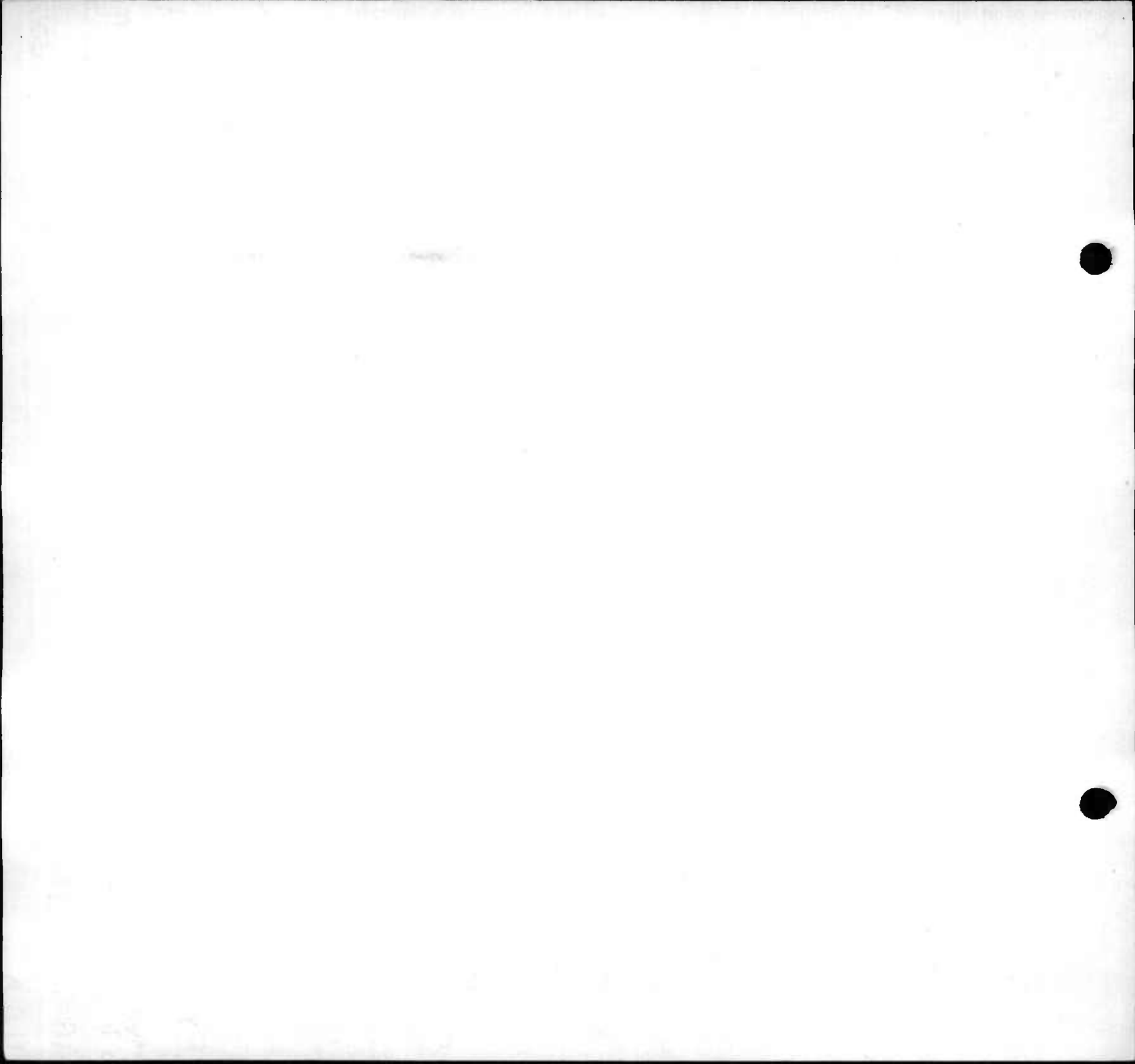
BIRTH NO. 66 00878				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00878	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>APR</i> <i>Mollie A. Boxer</i>				January 24, 1966 6:05 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <i>University of Maryland Hospital</i> (If not in hospital or institution, give street address or location) <i>38 University Hospital</i>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Rosewood State Hospital</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Owings Mills 6370</i> D. STREET ADDRESS (If rural, give location) <i>ROSEWOOD STATE HOSPITAL</i>			
5. SEX <i>Female</i>	6. RACE <i>Cauc.</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>never married</i>	8. DATE OF BIRTH <i>6-19-27</i>	9. AGE (In years last birthday) <i>39</i>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>NONE</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland, BALTIMORE</i>		
13. FATHER'S NAME <i>CHARLES BOXER</i>			14. MOTHER'S MAIDEN NAME <i>LILLY BRAUNSTEIN</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			16. SOCIAL SECURITY NO. <i>NO</i>		17. INFORMANT ADDRESS <i>MRS. ETTA SMULOWITZ 3709 BEEHLER AVE</i>		
18. <i>75711</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Congenital Polycystic DISEASE OF KIDNEYS + LIVER + Sepsis + uremia</i> (B) <i>uremia</i> (C)		INTERVAL BETWEEN ONSET AND DEATH <i>39 yrs.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) <i>None</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>None</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>None</i>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 5</i> 19 <i>66</i> to <i>Jan 24</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Jan 24</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Bernard S. Karpers Jr.</i> M.D.				Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>Jan 24 66</i>	
23C. PHYSICIAN'S NAME (Type) <i>BERNARD S. KARPERS JR.</i>				23D. ADDRESS M.D. <i>University Hospital BALD</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>1/25/66</i>		24C. NAME of CEMETERY or CREMATORY <i>BNAI JACOB</i>		24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MARYLAND</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 26 1966</i>		25B. NAME OF REGISTRAR <i>Q. B. S. F. D. W. A.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>SOLLEVI NSON & BROS. INC. 6010 REISTERSTOWN RD</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 66 00879	
BIRTH NO. M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BISHOP, EDWARD		2. DATE AND HOUR OF DEATH 1/23/66 1 PM M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 University Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 16-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1329 W. Mosher St.			
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Oct. 3, 1911	9. AGE (In years last birthday) 54	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fisherman		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hix Bishop				14. MOTHER'S MAIDEN NAME Sarah Johnson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1918		16. SOCIAL SECURITY NO. 217-07-5000		17. INFORMANT George Bishop		ADDRESS 1007 Woodyear St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 162.1 I BRONCHOGENIC CARINOMA INTERVAL BETWEEN ONSET AND DEATH 1 yr.							
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 3 11/16/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Bronchoscopy & Biopsy		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan. 10 1966 to Jan. 23 1966 , that (I) (we) last saw the deceased alive on Jan. 23 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Zalman S. Agus M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/23/66	
23C. PHYSICIAN'S NAME (Type) ZALMAN S. Agus M.D.				23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-26-66		24C. NAME OF CEMETERY OR CREMATORY Balto. Natl. Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1966		25B. NAME OF REGISTRAR Robert P. Jones		25C. FUNERAL DIRECTOR Agus S. Klor		ADDRESS 1348 N. Calhoun St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00880	
CERTIFICATE OF DEATH					
BIRTH NO. 66 00880					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) ROSE BAILEY (Rosie)		2. DATE AND HOUR OF DEATH 1/23/66 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE BALTO. MD. 16-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. D. STREET ADDRESS (If rural, give location) 822 NO. CAREY ST			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 36 Franklin Square Hosp.					
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Sept. 3, 1892	9. AGE (In years last birthday) 73	10. CITIZEN OF WHAT COUNTRY U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Hilery Smalwood		14. MOTHER'S MAIDEN NAME Rebecca Hawkins			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 245-05-6806		17. INFORMANT ADDRESS Catherine Webb 1118 N. Monroe St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.0 X 260 X ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Intussusception Heart Disease (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus				10 yrs	
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 24 1965 to Jan 23 1966, that (I) (we) last saw the deceased alive on Jan 14 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Roland T. Smoot				23B. DATE SIGNED 1/24/66	
23C. PHYSICIAN'S NAME (Type) ROLAND T. SMOOT				23D. ADDRESS 3817 COPLEY RD., BALTO. 15	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-27-66		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cem. Balto. Md.	
24D. LOCATION (City, town, or county) (State) Balto. Md.					
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1966		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR ADDRESS 1348 N. Calhoun St. George A. Nelson	

S-530 1

BALTIMORE CITY HEALTH DEPARTMENT

Registered No.

66 00881

CERTIFICATE OF DEATH

66 00881

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

James Edmund Smith

2. DATE AND HOUR OF DEATH

January 25, 1966 | 8:20 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

606 Harwood Ave.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

606 Harwood Ave.

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married

8. DATE OF BIRTH

8/7/1892

9. AGE (In years
last birthday)

73

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired Technician

10B. KIND OF BUSINESS OR INDUSTRY

Univ. of Md.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Paul Pallard Smith

14. MOTHER'S MAIDEN NAME

Mary Elizabeth O'Conner

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

015-32-1516

17. INFORMANT

Mrs. Beulah E. Smith (Same)

ADDRESS

18.

433.01

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 1965 to Jan. 1966,
that (I) (we) last saw the deceased alive on 3 Aug. 1965 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Com. H. Kammer, Jr.

M.D.

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

26 Jan. 1966

23C. PHYSICIAN'S
NAME (Type)

William H. Kammer, Jr. M.D.

23D. ADDRESS

6011 York Road

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1/27/1966

24C. NAME OF CEMETERY or CREMATORY

Green Mount

24D. LOCATION

Baltimore,

(City, town, or county)

(State)

Maryland

25A. DATE REC'D BY HEALTH DEPT.

JAN 26 1966

25B. NAME OF REGISTRAR

J. E. F. F.

25C. FUNERAL DIRECTOR

H.W. Jenkins & Sons Co. 4905 York Rd.

Balto. 12, Md.

For Approval
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

THE END OF THE LINE

66 00882

BALTIMORE CITY HEALTH DEPARTMENT

66 00882

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM

RTTZ

2. DATE AND HOUR PRONOUNCED DEAD

January 19, 1966

7:10 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

241 S. Conkling Street

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

241 S. Conkling Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married

8. DATE OF BIRTH

5/28/1899

9. AGE (In years
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired Roofer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

George Ritz

14. MOTHER'S MAIDEN NAME

Hannah Reed

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

216-05-2074

17. INFORMANT

ADDRESS

Mrs. Elizabeth Ritz 241 S. Conkling

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive and Arteriosclerotic
Heart Disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/20/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

Burial

1/22/66

Baltimore Cemetery

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JAN 26 1966

R. E. Farley

Joseph M. Zannino, 263 S. Conkling St

WALHEIM FOLIO

1800 CONTENT

1
W-435

66 00883

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 00883

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Caroline Weldon

2. DATE AND HOUR PRONOUNCED DEAD

1/25/66 8:15 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1418 N. Linwood Ave.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

widow

8. DATE OF BIRTH

1-26-1907

9. AGE (In years last birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Winnsboro, S. C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Brown Bailey

14. MOTHER'S MAIDEN NAME

Mrs. Jannie Bird

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

213-18-1384 Willis Weldon 1418 N. Linwood Ave

17. INFORMANT

ADDRESS

18.

443X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic and hypertensive cardio-vascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK

NOT WHILE AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/25/66

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

1-29-66

23C. NAME of CEMETERY or CREMATORY

Arbutus Mem pk

23D. LOCATION (City, town, or county)

Arbutus

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JAN 26 1966

Morton & Dyett 1701 Laurens St.

1-10-1953

1-10-1953

1-10-1953

1-10-1953

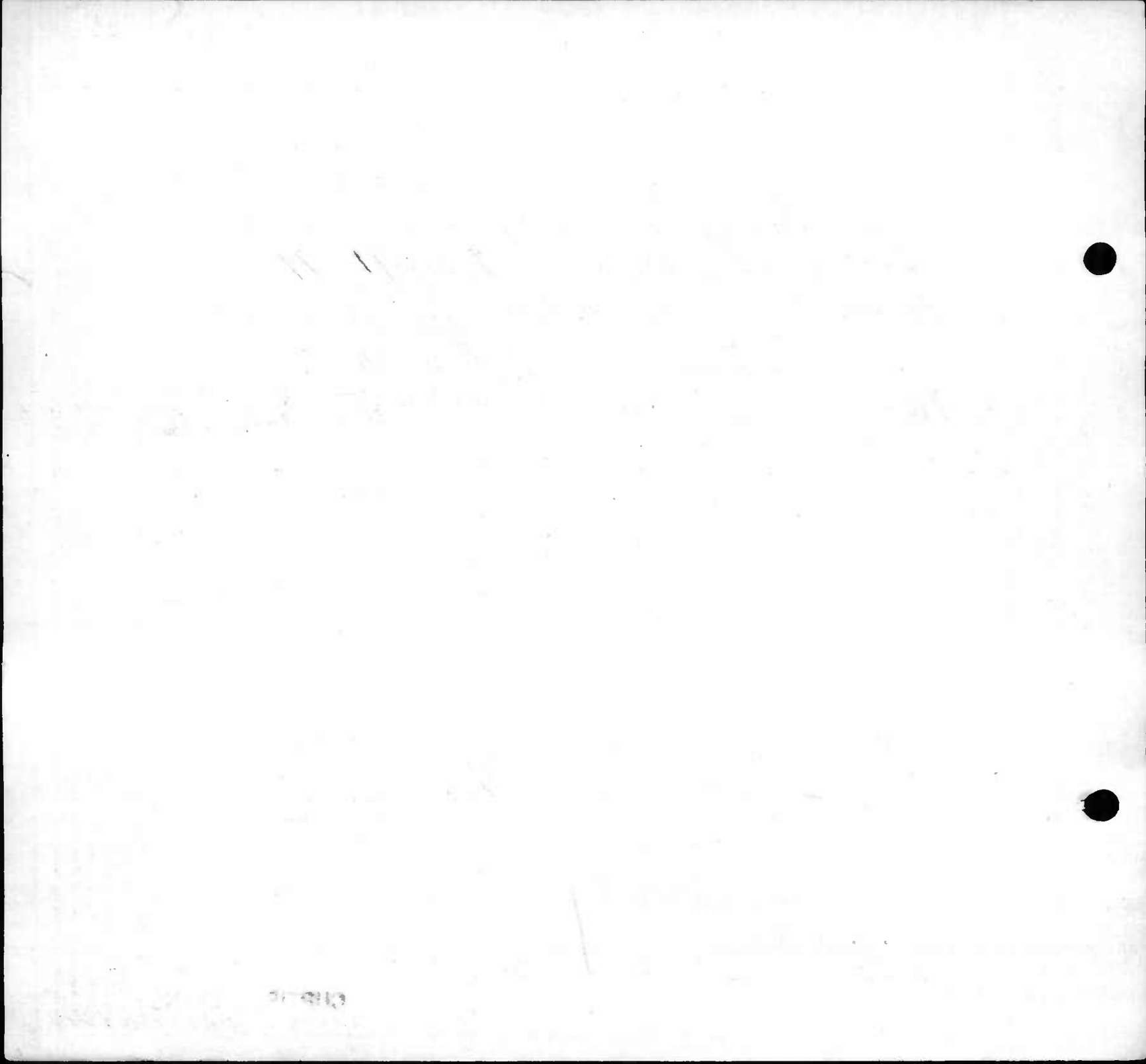
1-10-1953

1-10-1953

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

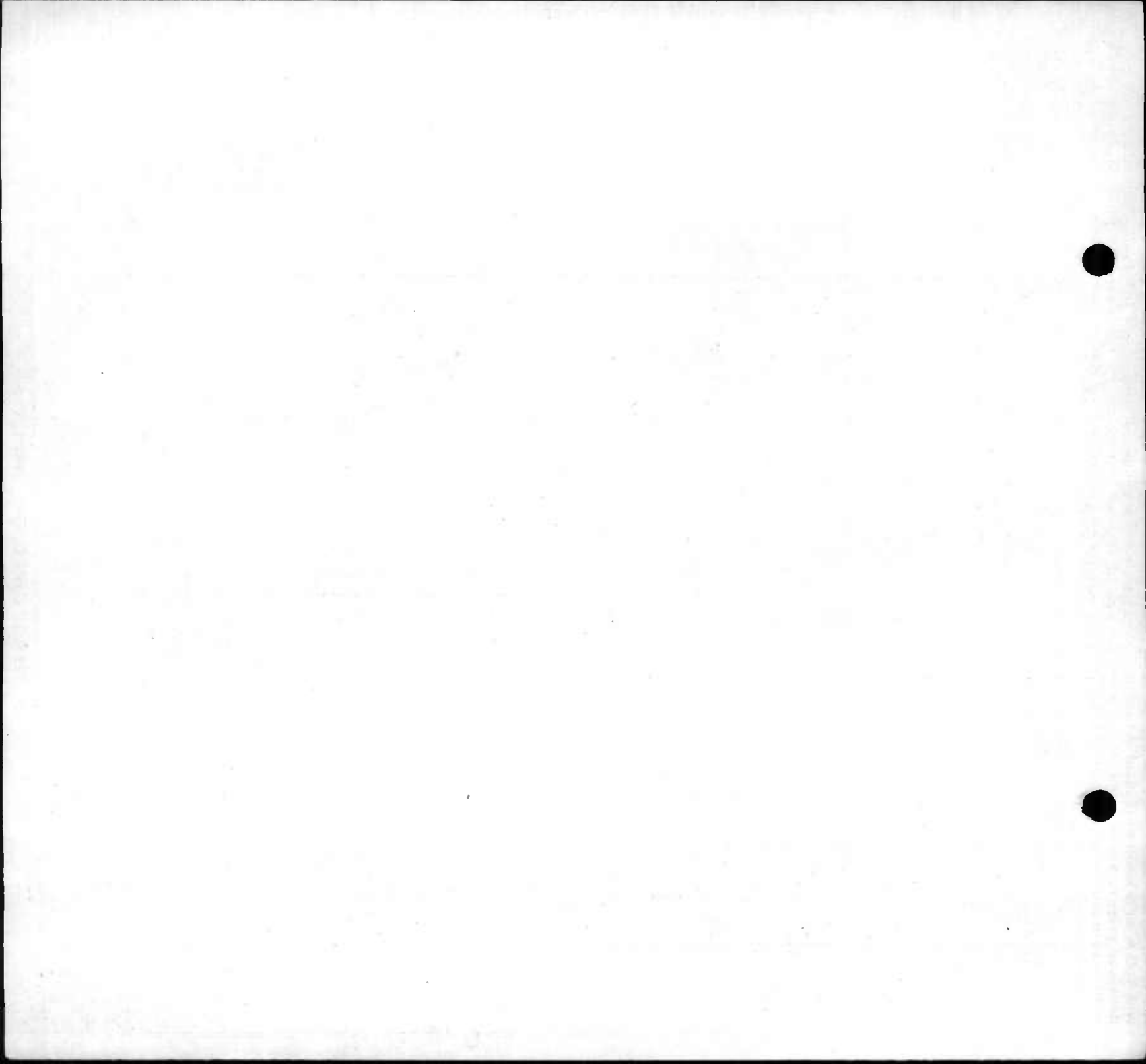
BIRTH NO. 66 00884				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00884	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Pearl H. Yuhas</u>				2. DATE AND HOUR OF DEATH <u>1-24-66</u> <u>1:19 P</u> M.			
3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>23-01</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>South Baltimore General Hosp</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore #2123d</u>			
				D. STREET ADDRESS (If rural, give location) <u>1044 S. Charles St.</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>9-8-1891</u>	9. AGE (In years last birthday) <u>74</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None at Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jeremiah Early</u>				14. MOTHER'S MAIDEN NAME <u>Emma P</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>12-5824</u>		17. INFORMANT <u>Marjannette P. Posie, Daughter</u>	
18. <u>443X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <u>CHF</u>				CAUSE OF DEATH (A) DUE TO <u>CHF</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>HASCU D</u>				(B) DUE TO			
				(C) DUE TO			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>ESOPHAGEAL STRICTURE</u>							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that the (this hospital) attended the deceased from <u>1-9</u> 19 <u>66</u> to <u>1-24</u> 19 <u>66</u> . that the (we) last saw the deceased alive on <u>1-24</u> 19 <u>66</u> and that in the (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Dr. M. Kauf</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1-24-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. M. Kaufmann</u>				23D. ADDRESS M.D. <u>South Baltimore General Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Jan 27-66</u>		24C. NAME OF CEMETERY or CREMATORY <u>U.S. Nat'l Cem</u>		24D. LOCATION (City, town, or county) (State) <u>Balto Md. Cont...</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1966</u>		25B. NAME OF REGISTRAR <u>Robert J. ...</u>		25C. FUNERAL DIRECTOR <u>CURTIS E. EVANS</u> ADDRESS <u>14005 CHARLES ST BALTO MD 21230</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REGISTERED NO. 66 00885	
BIRTH NO. 66 00885				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LOUIS RATH		2. DATE AND HOUR OF DEATH 1-23-66 11:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4407 ADELLE TERRACE			4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE MD. B. COUNTY BALTIMORE CITY C. CITY OR TOWN (If outside city limits, write RURAL and give township) 2804 D. STREET ADDRESS (If rural, give location) 4407 ADELLE TERRACE		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH Aug. 14, 1883	9. AGE (In years last birthday) 82	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WILLIAM L. RATH			14. MOTHER'S MAIDEN NAME REGENIA DAUB		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 220-44-3883	17. INFORMANT William R. Kelly ADDRESS 4407 Adelle Terr.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I Coronary Occlusion			CAUSE OF DEATH (A) DUE TO Coronary Occlusion (B) DUE TO Cardiovascular Disease (C) DUE TO Compensation		INTERVAL BETWEEN ONSET AND DEATH Sudden 3 weeks
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II Coronary Thrombosis & Partial Left Side Hemiplegia			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 10/19/54		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 10/19 1954 to 1/23 1966 , that (I) (we) last saw the deceased alive on 1/22 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Eliot W. Johnson			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/24/66
23C. PHYSICIAN'S NAME (Type) ELIOT W. JOHNSON			23D. ADDRESS 3432 FREDERICK AVE.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 1/26/66	24C. NAME of CEMETERY or CREMATORY GREEN MOUNT CEMETERY	24D. LOCATION (City, town, or county) (State) Baltimore Md.		
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1966		25B. NAME OF REGISTRAR R. B. Johnson	25C. FUNERAL DIRECTOR F. B. WIPPERT		ADDRESS 1300 EUTAW PI.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
66 00886						Registered No. 66 00886					
BIRTH NO.						M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>Harry A. Hergett</u>						2. DATE AND HOUR OF DEATH <u>JAN 23, 1966</u> <u>1:25</u> P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hosp</u> <u>Balto Md</u>						A. STATE <u>Md</u> B. COUNTY <u>Anne Arundel</u>					
(If not in hospital or institution, give street address or location)						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Jessup</u> <u>32-00</u>					
D. STREET ADDRESS (If rural, give location) <u>Clark Rd</u>											
5. SEX <u>M</u>	6. RACE <u>Can</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <u>8-8-99</u>	9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Supervisor U.S. Civil Service</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Benjamin Hergett</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth (Unknown)</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>No</u>						16. SOCIAL SECURITY NO. <u>577-38 7060</u>		17. INFORMANT <u>Harry A. Hergett (Son)</u>		ADDRESS <u>same</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>HEPATIC DEGENERATION OF LIVER</u>						INTERVAL BETWEEN ONSET AND DEATH					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <u>2</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work				21F. HOW DID INJURY OCCUR?			
22. I certify that <u>HT</u> (this hospital) attended the deceased from <u>1-19</u> 19 <u>66</u> to <u>1-23</u> 19 <u>66</u> , that (I) <u>we</u> last saw the deceased alive on <u>1/23</u> 19 <u>66</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) (did not) view the body after death.											
23A. SIGNATURE <u>Donald T. Lewers M.D.</u>								23B. DATE SIGNED <u>1-23-66</u>			
23C. PHYSICIAN'S NAME (Type) <u>Donald T. Lewers</u>								23D. ADDRESS <u>Md. Gen Hosp</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>Jan. 27/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Cedar Hill Cemetery</u>				24D. LOCATION (City, town, or county) (State) <u>Brooklyn RFD, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1966</u>				25B. NAME OF REGISTRAR <u>Robert M. ...</u>				25C. FUNERAL DIRECTOR <u>Singleton Funeral Home / Glen Burnie</u>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00887				CITY OF BALTIMORE		CITY OF BALTIMORE		CITY OF BALTIMORE	
M.E. CASE NO.				REGISTERED NO.		66 00887		66 00887	
1. NAME OF DECEASED (Type or Print) ASHBY RICHARD Mc MULLEN				2. DATE AND HOUR OF DEATH JAN 22, 1966 2 55 PM.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY HUN ARUNDEL					
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township) FERNDALE, MD.					
D. STREET ADDRESS (If rural, give location) 19 VISTA AVE									
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 3/30/44	9. AGE (in years last birthday) 21	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ast. Machinist			10B. KIND OF BUSINESS OR INDUSTRY Mt. Box Co.			11. BIRTHPLACE (State or foreign country) Balto., MD.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ASHBY R. Mc MULLEN				14. MOTHER'S MAIDEN NAME SARA WORKMAN					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Sarah L. McMullen (mother)			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) BLEEDING DIATHESIS, GENERALIZED				CAUSE OF DEATH CONFIRMING TO THE DEATH					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CHRONIC LIVER DISEASE CHRONIC RHEUMATIC HEART DISEASE				INTERVAL BETWEEN ONSET AND DEATH 2 YRS. SINCE CHILDHOOD					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING IT. INTRACEREBRAL HEMORRHAGE				21. CONDITION DIRECTLY LEADING TO DEATH INTRACEREBRAL HEMORRHAGE					
21A. DATE OF OPERATION		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. AUTOPSY? (Yes or No) YES		21D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1/25 19 66 to 1/22 19 66 , that (I) (we) last saw the deceased alive on 1/25 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Ronald L. Paul				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/22/66			
23C. PHYSICIAN'S NAME (Type) Ronald L. Paul				23D. ADDRESS University Hospital, Balto. Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan. 25/66		24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial Park		24D. LOCATION (City, town, or county) (State) Glen Burnie, Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1966		25B. NAME OF REGISTRAR R. V. Singleton		25C. FUNERAL DIRECTOR ADDRESS Glen Burnie, Md.					

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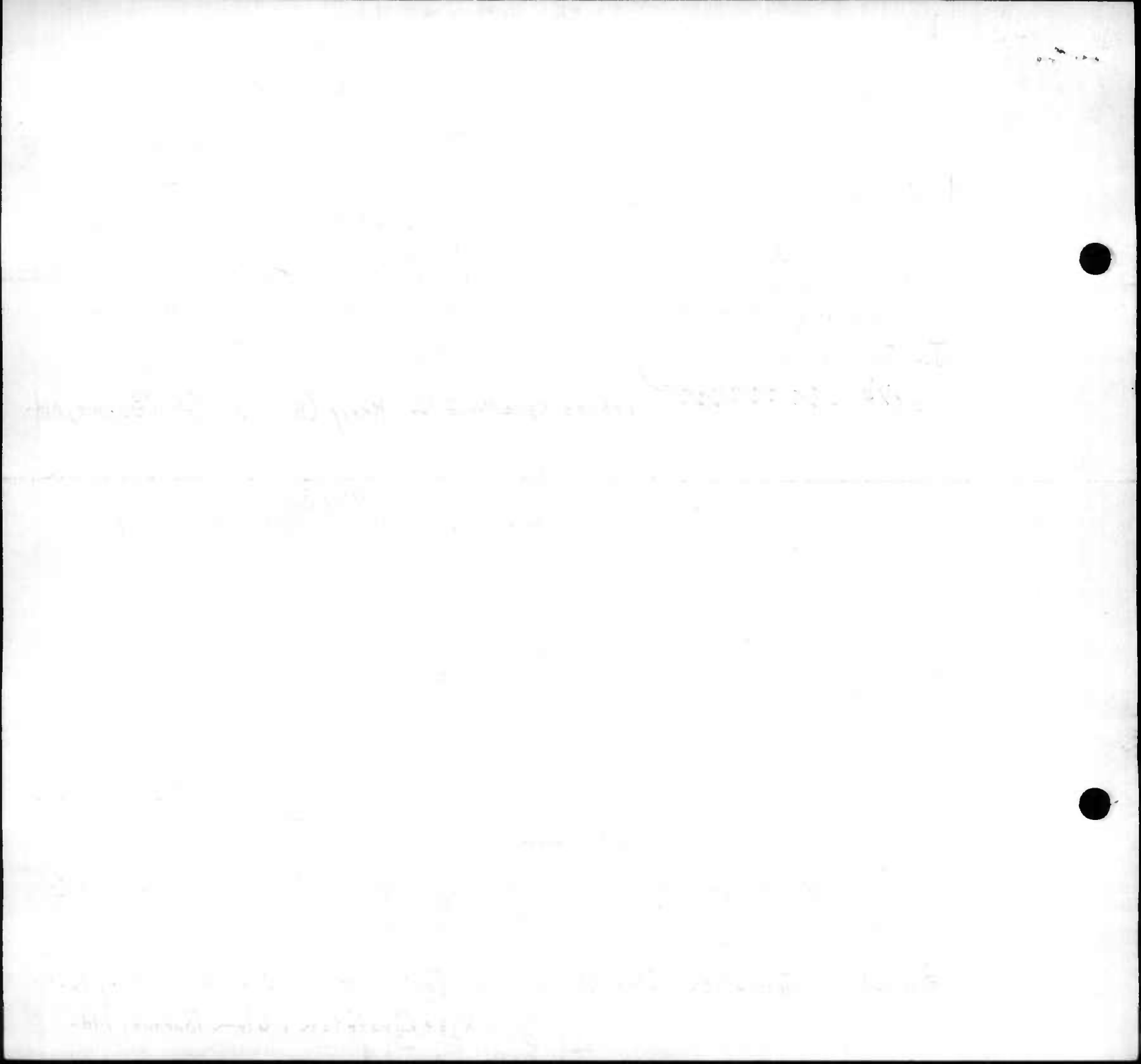
11-8

11-8

FUNERAL DIRECTOR: IMPORTANT

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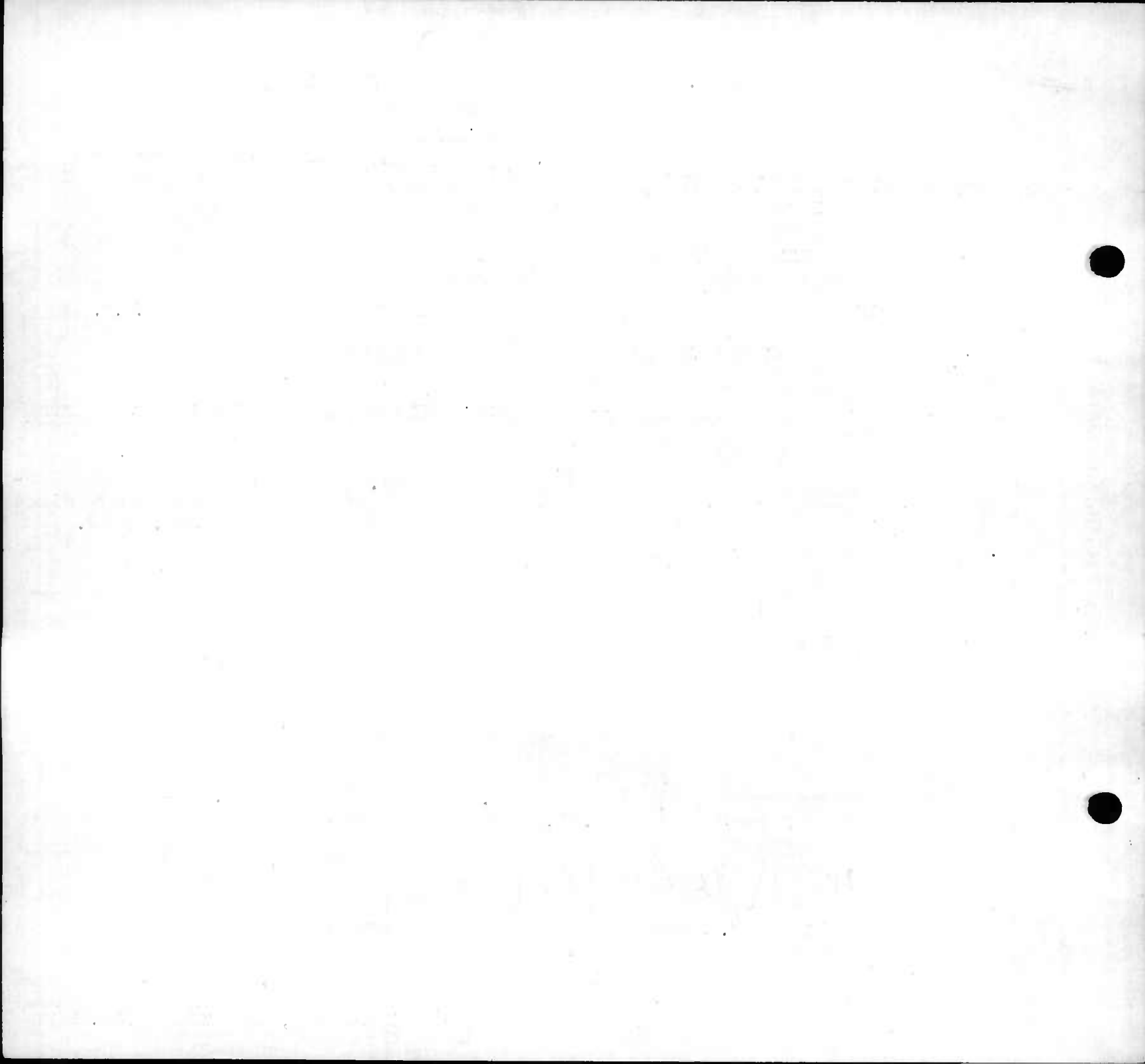
BIRTH NO.		66 00888		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 00888	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <u>John Thomas Dunn</u>					
2. DATE AND HOUR OF DEATH <u>1/21/66</u> <u>9:30 P.M.</u>				3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u>					
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Anne Arundel</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Glen Burnie 5200</u>		D. STREET ADDRESS (If rural, give location) <u>7509 Furnace Branch Rd. Apt.</u>					
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <u>11/27/13</u>	9. AGE (In years lost birthday) <u>52</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>petroleum inspector</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>U.S. Air Force</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
3. FATHER'S NAME <u>John T. Dunn</u>				4. MOTHER'S MAIDEN NAME <u>Mary Kerrigan</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>173-05-5894</u>		17. INFORMANT <u>Mrs. Eileen Keagy (Daughter)</u>		ADDRESS <u>Glen Burnie, Md.</u>	
18. <u>581.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(A) DUE TO <u>Bleeding Esophageal Varices</u>		(B) DUE TO <u>Laennec's Cirrhosis</u>		(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>Tracheostomy 1/12/66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Tracheostomy</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <u>he</u> (this hospital) attended the deceased from <u>1/19</u> 19 <u>66</u> to <u>1/21</u> 19 <u>66</u> . that <u>he</u> (we) last saw the deceased alive on <u>1/21</u> 19 <u>66</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>did</u> (did not) view the body after death.									
23A. SIGNATURE <u>Bernard du Buy</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1/21/66</u>			
23C. PHYSICIAN'S NAME (Type) <u>Bernard du Buy</u>				23D. ADDRESS <u>University Hospital</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Jan 25/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Glen Haven Mem. Park</u>		24D. LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1966</u>				25B. NAME OF REGISTRAR <u>R. A. Sigler</u>		25C. FUNERAL DIRECTOR <u>R. A. Sigler, Glen Burnie, Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 00889		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00889	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		NELLIE M. SPIEKERMAN		2. DATE AND HOUR OF DEATH JANUARY 23, 1966	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		M. 25-41	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
90 WINDSOR NURSING HOME 3025 WINDSOR AVENUE		BALTIMORE		D. STREET ADDRESS (If rural, give location) 1104 HAVERHILL ROAD 21229	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 5/9/77	9. AGE (In years last birthday) 88	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILLIAM JENKINS		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -----		17. INFORMANT MISS MAUD MULLER, 1104 HAVERHILL ROAD 21229	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 442X1 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cardiovascularrenal Disease ? Has been Loud murmurs. (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH in Windsor Nursing Home since Oct. 1949.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from Feb. 1965 19 to Jan. 23-66 19, that (I) (we) last saw the deceased alive on Jan. 21, 1966 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE W. R. Johnson		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) WILLIAM R. JOHNSON	
23D. ADDRESS 4008 EDMONDSON AVENUE		23E. M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/26/66		24C. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JAN 26 1966		25B. NAME OF REGISTRAR Robert E. Johnson	
25C. FUNERAL DIRECTOR HUBBARD FUNERAL HOME, 4107 WILKENS AVE. 21229		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

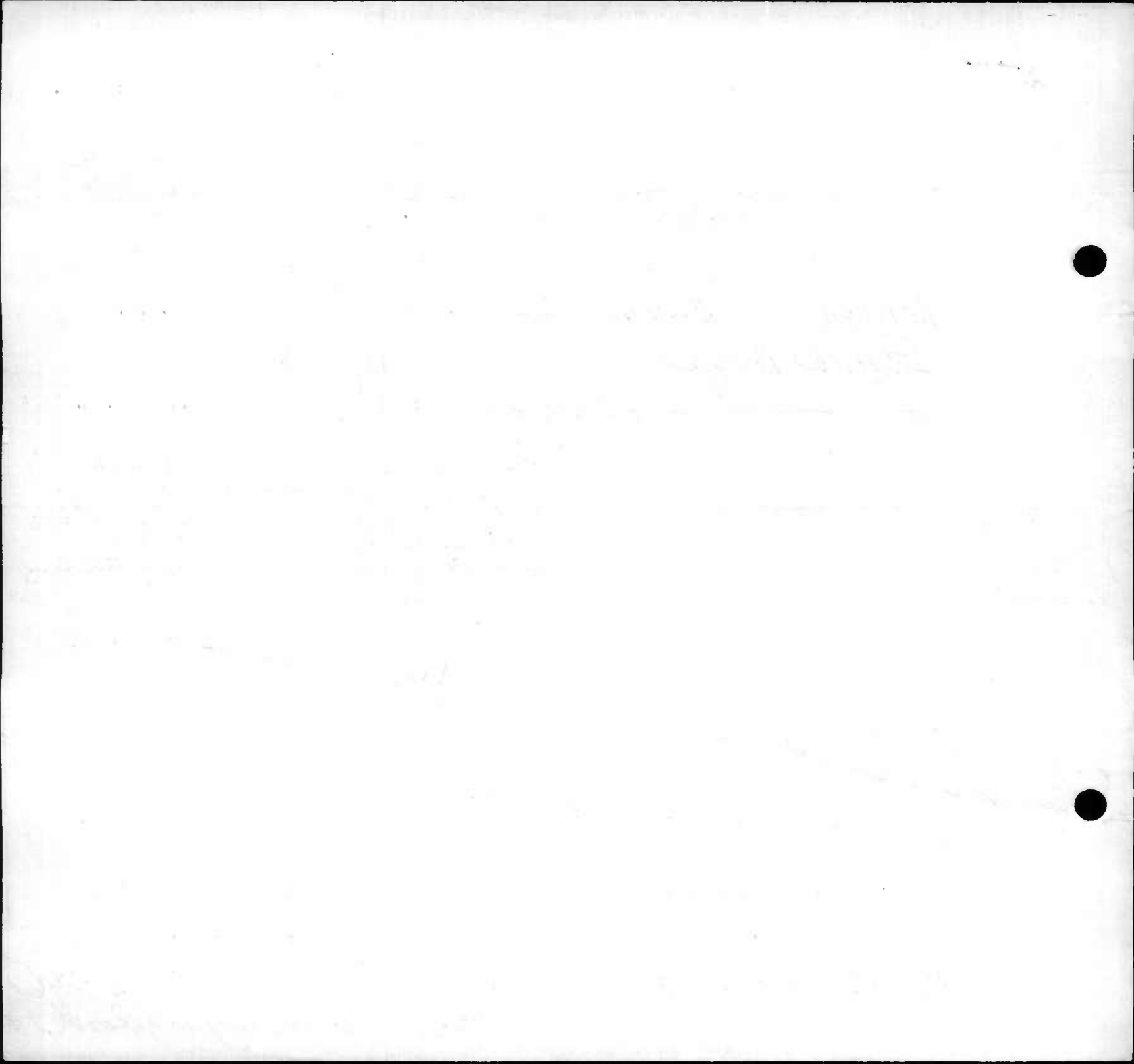
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 00890					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 66 00890				
1. NAME OF DECEASED (Type or Print) BALDWIN, Charles Elliott					2. DATE AND HOUR OF DEATH January 21, 1966 7:10 a M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Prince George				
FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Accokeek				
					D. STREET ADDRESS (If rural, give location) Rt 1, Box 155-C				
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8/3/11	9. AGE (In years last birthday) 54	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman			10B. KIND OF BUSINESS OR INDUSTRY Unemployed		11. BIRTHPLACE (State or foreign country) Accokeek, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Randolph Baldwin					14. MOTHER'S MAIDEN NAME Nellie Elliott				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 7/16/42 - 11/29/45			16. SOCIAL SECURITY NO. 577-03-09-19		17. INFORMANT ADDRESS VA Hospital Records Baltimore, Md 21218				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Bronchogenic carcinoma (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH 1 year				
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that X (this hospital) attended the deceased from December 7th 19 65 to January 21st 19 66 , that (A) (we) last saw the deceased alive on January 21st 19 66 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. XX (We) (did) (XXXX) view the body after death.									
23A. SIGNATURE John S. Howe					23B. DATE SIGNED 1/21/66				
23C. PHYSICIAN'S NAME (Type) John S. Howe			23D. ADDRESS VA Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan. 25 1966		24C. NAME OF CEMETERY or CREMATORY Arlington National		24D. LOCATION (City, town, or county) (State) Arlington, Virginia			
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1966			25B. NAME OF REGISTRAR John S. Howe		25C. FUNERAL DIRECTOR ADDRESS The Hunt Funeral Home, Waldorf, Md.				

[Handwritten signature]



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-100 BIRTH NO.		66 00891		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00891	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print)				BOPP, Gregory		1/23/66 9:30 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
BALTIMORE CITY HOSPITALS		4940 Eastern Avenue Baltimore, Maryland 21224		MARYLAND		8-02	
5. SEX				6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
Male		White		Married		2/19/89 76	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
RETIRED				Baltimore Co		MARYLAND	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Frank Bopp				Miller			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
No				913-10-0106		ADDRESS RECORDS: BCH 4940 Eastern Ave., Balto. Md. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) Pneumonia		1 week	
ANTECEDENT CAUSES				(B) Severe dehydration + debility			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Aortic and mitral valve insufficiency - long standing			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) Rheumatic heart disease		long standing	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2						Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1/21 1966 to 1/23 1966, that (I) (we) last saw the deceased alive on 1/23 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Leonard J. Quadracci						1/23/66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
LEONARD J. QUADRACCI				M.D. 4940 Eastern Avenue, Balto, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		1-26-66		Baltimore Cemetery		Baltimore - Balto Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 26 1966		Robert E. Jankins		Leonard J. Quadracci		40700 Harford Road	



BIRTH NO.

66 00892

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Bentio M. Lamartina

2. DATE AND HOUR PRONOUNCED DEAD

1/22/66 7:00 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1340 Silverthorn Rd.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

OCT-3-1929

9. AGE (In years
last birthday)

36

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

DELIVERY MAN

10B. KIND OF BUSINESS OR INDUSTRY

KOONTZ CREAMERY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ROSARIO LAMARTINA

14. MOTHER'S MAIDEN NAME

CONCETTINE ALMA

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

36-24-5607

17. INFORMANT

JANET LAMARTINA 1340 SILVERTHORNE RD

ADDRESS

18.

422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)Arteriosclerotic cardiovascular disease
(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type) Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

1/23/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

1-26-66

23C. NAME of CEMETERY or CREMATORY

HOLY REDEEMER

23D. LOCATION

BELAIR ROAD

(City, town, or county)

(State)

BALTO MD

24A. DATE REC'D BY HEALTH DEPT.

JAN 26 1966

24B. NAME OF REGISTRAR

R. E. J. J. J.

24C. FUNERAL DIRECTOR

LEO G. COOK

720 HARFORD ROAD

ADDRESS

WALTON POLICE

James J. [Signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 66 00893	
BIRTH NO. 66 00893		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SIMPSON JAMES E		2. DATE AND HOUR OF DEATH 1-23-66 1:15 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SOUTH BALTO. GEN. HOSP 123 LIGHT ST. BALTO, MD 21230				A. STATE Md B. COUNTY 8-03			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTmore 21213				D. STREET ADDRESS (If rural, give location) 2625 GROGAN AVE			
5. SEX M	6. RACE B (Caucasian)	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7-13-15	9. AGE (In years lost birthday) 50	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BEILER CLEANER			10B. KIND OF BUSINESS OR INDUSTRY SUGAR BEILER CLEANER		11. BIRTHPLACE (State or foreign country) NC		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Thomas Eugene Simpson				14. MOTHER'S MAIDEN NAME WILLIE MCCOY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Records	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 150X I CAUSE OF DEATH (A) DUE TO CA Esophagus (SQUAMOUS CELL CARCINOMA) (B) S DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH 1 YR.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that the (this hospital) attended the deceased from 12-15-65 19 to 1-23-66 19 that we (we) last saw the deceased alive on 1-23 19 66 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Francis A. DeBoer M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-23-66	
23C. PHYSICIAN'S NAME (Type) NARCISO A. DE BORJA M.D.				23D. ADDRESS 123 LIGHT ST, BALTO, MD. 21230			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/28/66		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Westport Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1966		25B. NAME OF REGISTRAR Robert E. Starnes		25C. FUNERAL DIRECTOR Frank T. Erickson		ADDRESS 11477 Greenleaf	

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1
C-350

66 00891

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 00891

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

William C. Cotton

2. DATE AND HOUR PRONOUNCED DEAD

1/23/66 12:20 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1223 N. Dallas St.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1223 N. Dallas St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

April 16 1900

9. AGE (In years last birthday)

65

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

BIRTHPLACE (State or foreign country)

Towson, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

William Cotton

14. MOTHER'S MAIDEN NAME

Lucy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Paula Cotton 1223 N. Dallas St.

18.

422.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/23/66

23A. BURIAL CREMATION, REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JAN 26 1966

Ed. E. Farber, M.D.

Howard P. Elickson 1129 N. Calhoun

VALLEY FORDGE

BIRTH NO. 66 00895 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 00895

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES GARDNER

2. DATE AND HOUR PRONOUNCED DEAD

1-23-66

4:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

PROVIDENT HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2211 Linden Avenue

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

1939 21

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

James Gardner

14. MOTHER'S MAIDEN NAME

Annie Cotes

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Annie Cotes 2211 Linden Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gunshot wound of chest and abdomen
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

N.W. Corner Linden Ave. & Ducatel Street

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

1 23 '66 PM 2:25

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Gunshot wound of chest

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-24-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1-27-66

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

Baltimore

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

JAN 26 1966

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Brooks Ringgold

ADDRESS

WALLEY FORGE

WALLEY FORGE

WALLEY FORGE

WALLEY FORGE

WALLEY FORGE

WALLEY FORGE

WALLEY FORGE

WALLEY FORGE

WALLEY FORGE

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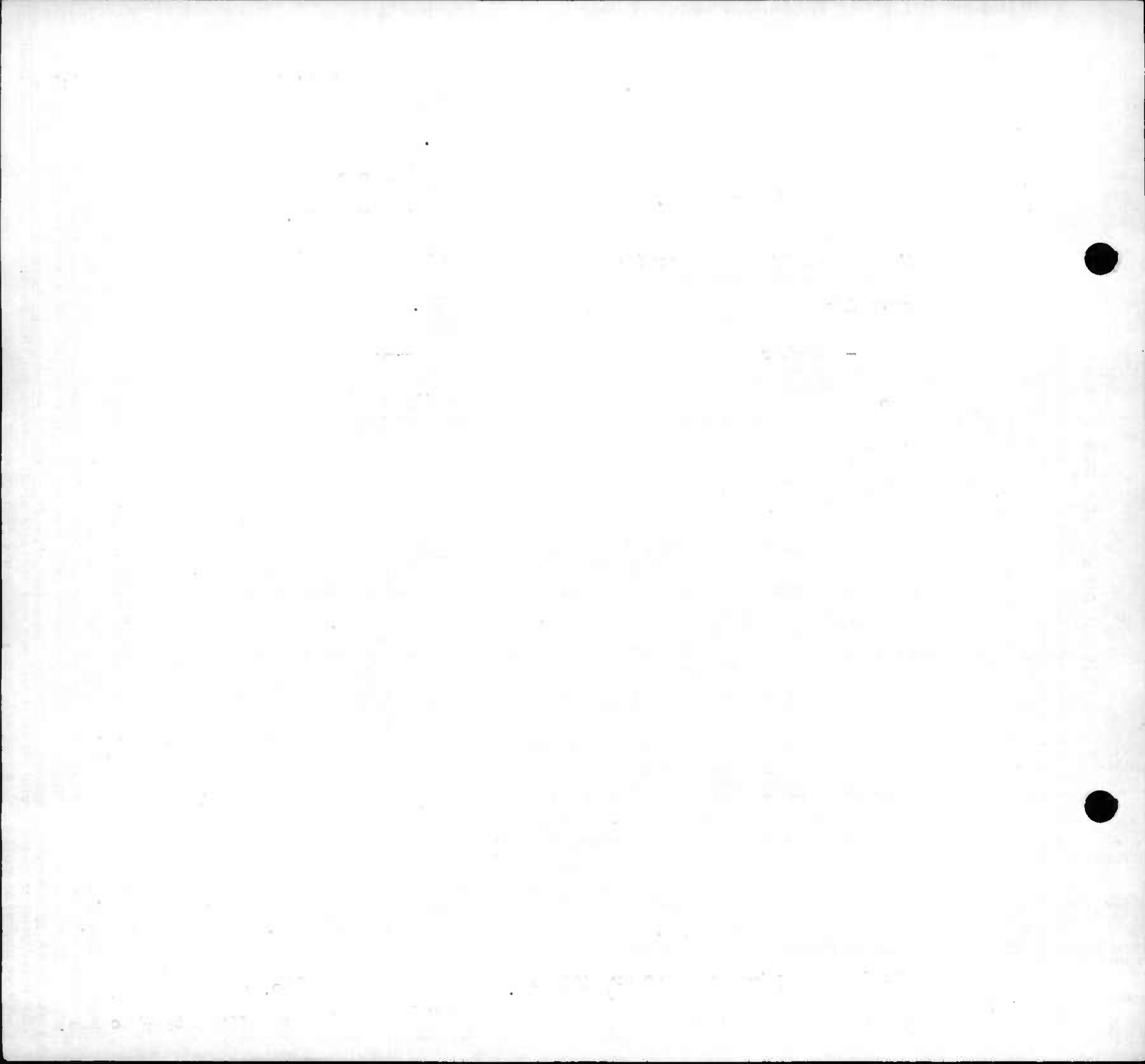
WALLEY FORGE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 00896

Registered No. 66 00896

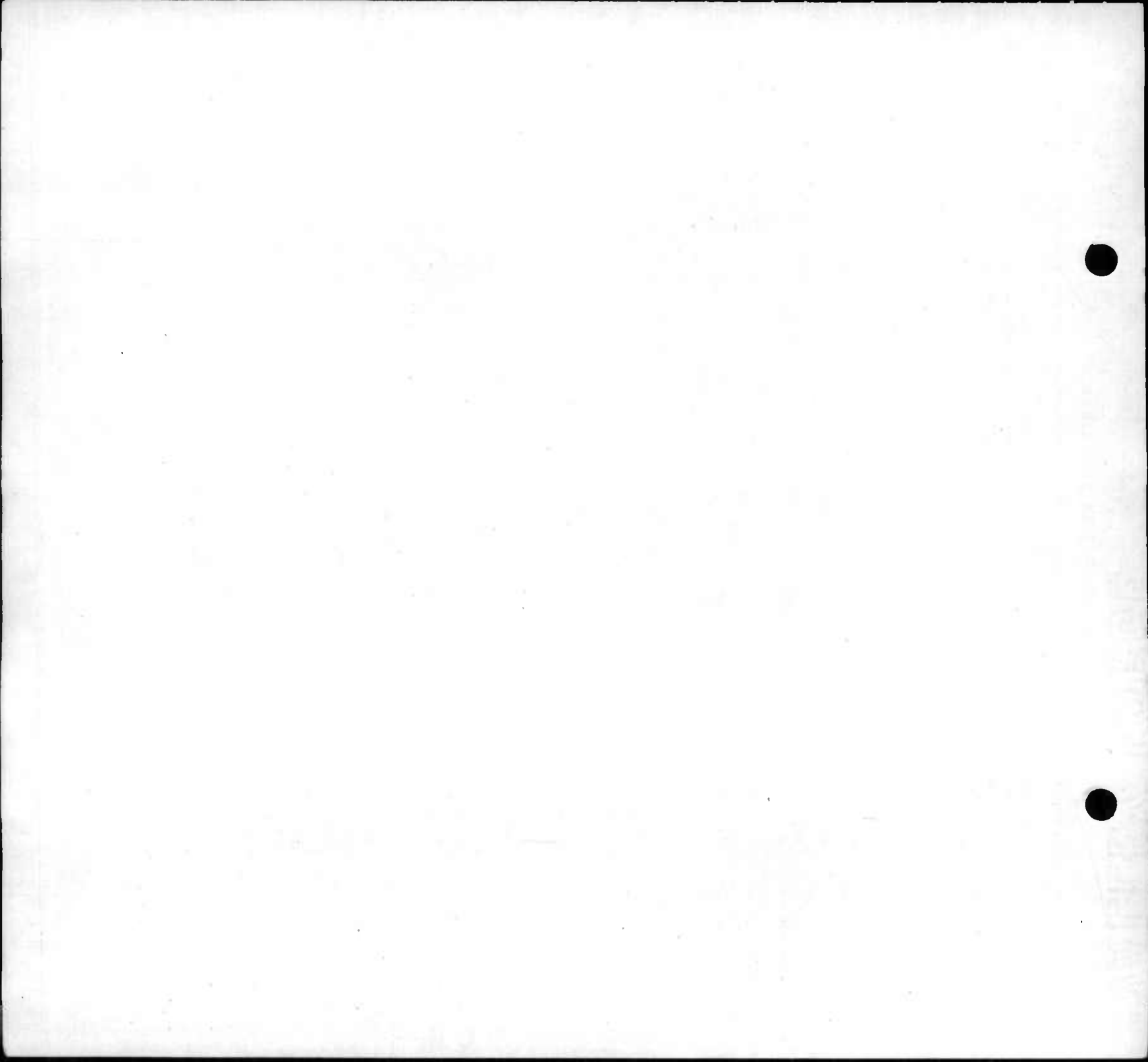
VS 150-REV. 1/1/65



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00897	
BIRTH NO. 66 00897		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Selma G. Cecil			
2. DATE AND HOUR OF DEATH Jan. 23, 1966		11:45 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lake Drive Nursing Home 2401 Eutaw Place Baltimore, Md.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland 21218 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 916 McKewin Avenue			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Aug. 5, 1884	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10B. KIND OF BUSINESS OR INDUSTRY Nursing		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Frank Gibson		14. MOTHER'S MAIDEN NAME Maud Thompson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-03-6938A		17. INFORMANT Thomas Cecil (Son) Same	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardio-vascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 2 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 1946 to JAN. 1966 , that (I) (we) last saw the deceased alive on JAN. 16 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Com. H. Kammer, Jr.				23B. DATE SIGNED JAN. 25, 1966	
23C. PHYSICIAN'S NAME (Type) Wm. H. Kammer, Jr.		23D. ADDRESS 6011 York Road			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/26/1966		24C. NAME OF CEMETERY or CREMATORY Monocacy Cemetery	
24D. LOCATION (City, town, or county) (State) Beallsville, Md.		25A. DATE RECEIVED BY HEALTH DEPT. JAN 27 1966			
25B. NAME OF REGISTRAR Robert E. Seitz		25C. FUNERAL DIRECTOR Eugenia K. Seitz			
25D. ADDRESS 5209 York Road		25E. ADDRESS Seitz Funeral Home Balto. Md. 21212			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 66 00898	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		66 00898		MYERS, MYRTLE F.		1/24/66 14:44 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
MD. Gen. Hosp.				Baltimore, Md.			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				D. STREET ADDRESS (If rural, give location)			
				620 S. DEAN ST.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
F	W	Widowed	8-18-95	70	HW	Balto, Md	USA
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Faber				Estelle Foreman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No						Mrs. Mildred E. Doyle-620 S. Dean St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
578X I				Septic Shock			
ANTECEDENT CAUSES				(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Clostridial Infection			
				(B) DUE TO			
				UGI hemorrhage			
				(C) DUE TO			
II				INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				18 hrs			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
1-23-66		UGI hemorrhage		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work					
22. I certify that (I) (this hospital) attended the deceased from 1-16-66 to 1-24-66 that (I) (we) last saw the deceased alive on 1-24-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
T. G. DODENHOFF						1-24-66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
T. G. DODENHOFF				MD. Gen. Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		1-27-66		Oak Lawn Cemetery		Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 27 1966		R. B. Estabrook		J. C. McElroy		Funeral Home 415 Belair Rd.	

1-24-66

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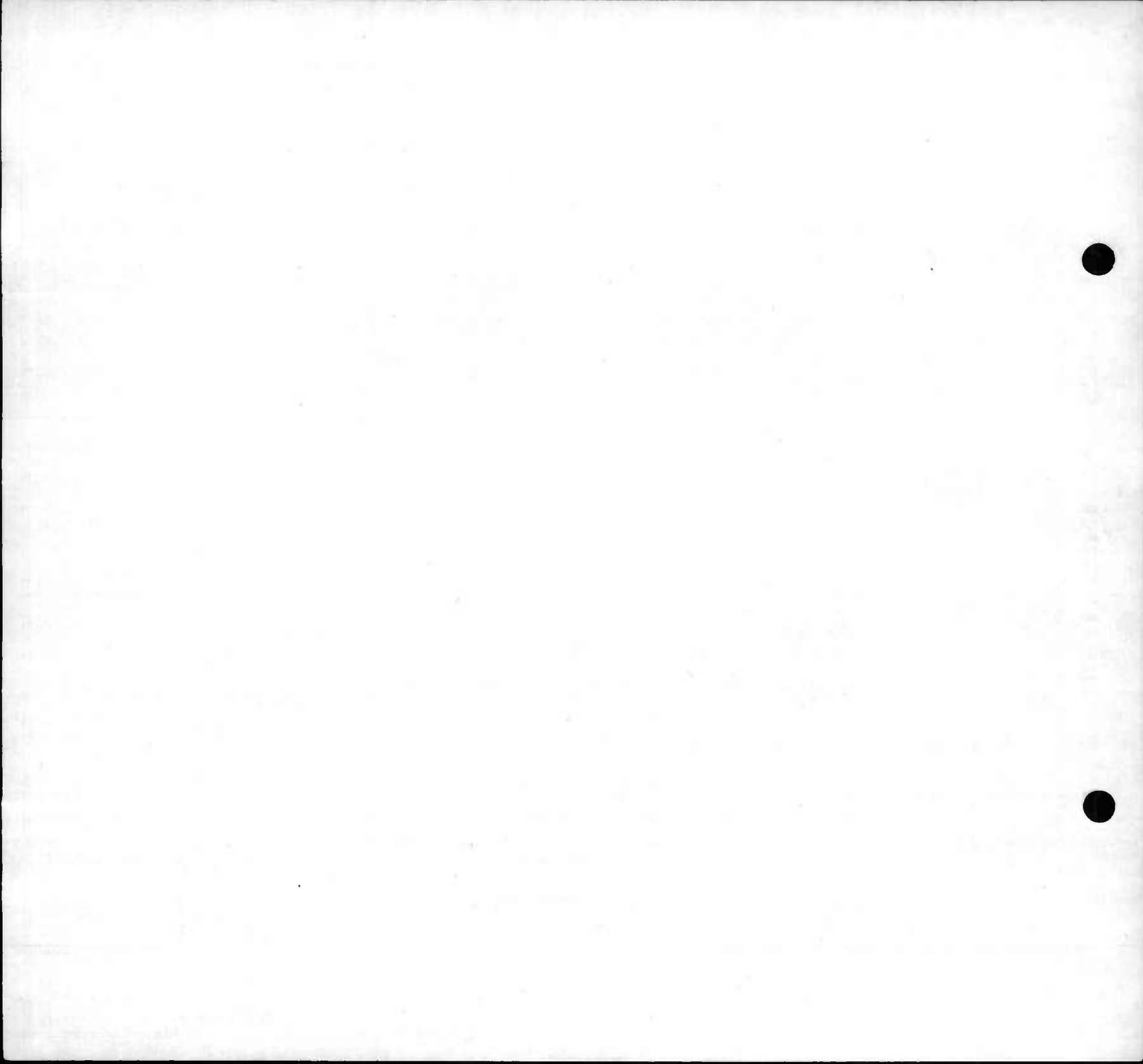
1-24-66

1-24-66
1-24-66

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
66 00899 CERTIFICATE OF DEATH						Registered No. 66 00899					
BIRTH NO.						M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>LAKE, JAMES</u>						2. DATE AND HOUR OF DEATH <u>1/24/66</u> <u>11:50 P.M.</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY HOSPITAL</u>						A. STATE <u>MD</u> B. COUNTY <u>PASADENA</u>					
FULL NAME OF (If not in hospital or institution, give street address or location)						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>PASADENA MD.</u>					
						D. STREET ADDRESS (If rural, give location)					
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>10/27/98</u>		9. AGE (In years last birthday) <u>67</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JAMES LAKE</u>						14. MOTHER'S MAIDEN NAME <u>LUCY RIDENOUR</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-09-467</u>		17. INFORMANT ADDRESS					
18. <u>332X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Infarction of CNS, edema</u> INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>											
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Thrombosis of carotid arteries Unknown</u> <u>Atherosclerosis, marked Unknown</u>											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>None</u>											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Carotid Thrombosis</u>				20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>No</u>				21C. WHERE DID INJURY OCCUR? <u>No</u>		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) <u>No</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR? <u>No</u>					
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>19</u> to <u>19</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>JANUARY 24</u> 19 <u>66</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> (did) (did not) view the body after death.											
23A. SIGNATURE <u>Timothy Kenney Gray</u> M.D.						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1-24-66</u>			
23C. PHYSICIAN'S NAME (Type) <u>TIMOTHY KENNEY GRAY</u> M.D.						23D. ADDRESS <u>University Hospital</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL-TRANSIT</u>		24B. DATE <u>1-24-66</u>		24C. NAME OF CEMETERY OR CREMATORY <u>RIVERVIEW</u>		24D. LOCATION (City, town, or county) (State) <u>STRASBURG, VIRGINIA</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 27 1966</u>		25B. NAME OF REGISTRAR <u>Paul E. Taylor</u>		25C. FUNERAL DIRECTOR <u>FRED A. COLE HOME</u>		ADDRESS <u>1913W BALTO. ST. BALTO. MD.</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

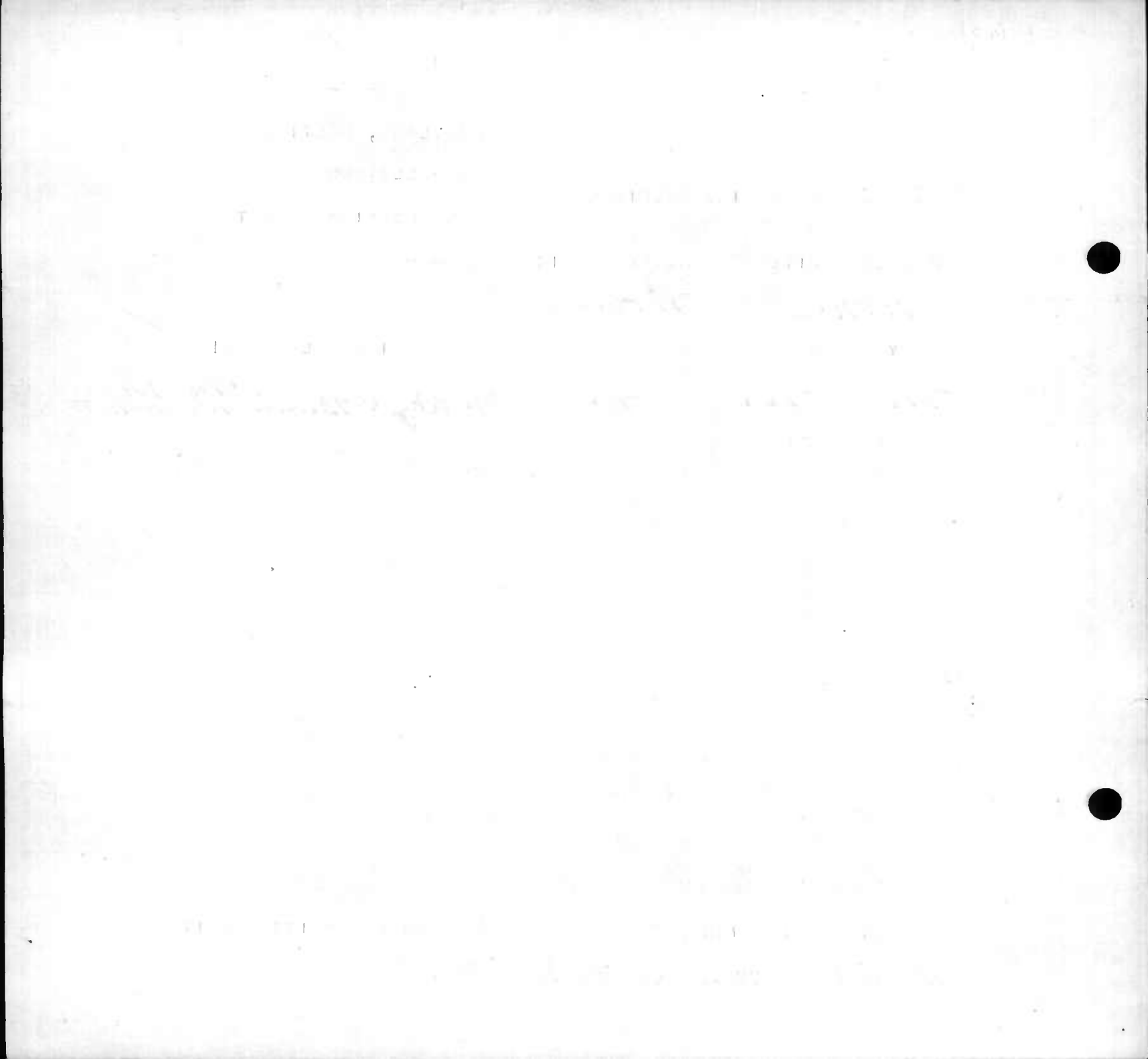
B-6351										66 00900										BALTIMORE CITY HEALTH DEPARTMENT										66 00900										187																			
BIRTH NO.										M.E. CASE NO.										1. NAME OF DECEASED (Type or Print)										2. DATE AND HOUR OF DEATH																													
																				Frank Barton										Jan. 23 rd 1966 - 4 ⁰⁰ P.M.																													
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)										A. STATE B. COUNTY																													
										Bolton Hill Nursing Center										Maryland										3-01																													
																				C. CITY OR TOWN (If outside city limits, write RURAL and give township)										Baltimore, Md.																													
																				D. STREET ADDRESS (If rural, give location)										1636 Eastern Ave.																													
5. SEX										6. RACE										7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)										8. DATE OF BIRTH										9. AGE (In years last birthday)										If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.									
M										W																				June 12 1901										65																			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)										10B. KIND OF BUSINESS OR INDUSTRY										11. BIRTHPLACE (State or foreign country)										12. CITIZEN OF WHAT COUNTRY?																													
Store Detective																				England																																							
13. FATHER'S NAME										14. MOTHER'S MAIDEN NAME																																																	
Alfred Barton										Bertha Guest										England																																							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)										16. SOCIAL SECURITY NO.										17. INFORMANT ADDRESS																																							
										214-10-9955										Wife (Same as above)																																							
18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)										CAUSE OF DEATH										INTERVAL BETWEEN ONSET AND DEATH																																							
										(A) carcinoma, right lung										5-6 months																																							
										(B) DUE TO																																																	
										(C) DUE TO																																																	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										coronary artery disease										several months																																							
19A. DATE OF OPERATION										19B. CONDITION FOR WHICH OPERATION WAS PERFORMED										20A. AUTOPSY? (Yes or No)										20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
0																				no																																							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)										21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)										21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)																																							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)										21E. INJURY OCCURRED										21F. HOW DID INJURY OCCUR?																																							
										White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>																																																	
22. I certify that (I) (this hospital) attended the deceased from 1-15-66 to Jan 23 1966, that (I) (We) lost saw the deceased alive on 1-23-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																																																											
23A. SIGNATURE										23B. DATE SIGNED																																																	
E. Ellsworth Cole										1-23-66																																																	
23C. PHYSICIAN'S NAME (Type)										23D. ADDRESS																																																	
24A. BURIAL CREMATION, REMOVAL (Specify)										24B. DATE										24C. NAME OF CEMETERY or CREMATORY										24D. LOCATION (City, town, or county) (State)																													
Burial										1/26/66										Balto. National										Balto. Md.																													
25A. DATE REC'D BY HEALTH DEPT.										25B. NAME OF REGISTRAR										25C. FUNERAL DIRECTOR										ADDRESS																													
JAN 27 1966										Robert E. Taylor										J. J. Cronley Sons										300 Mac (21)																													

W. B. D. D. D.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

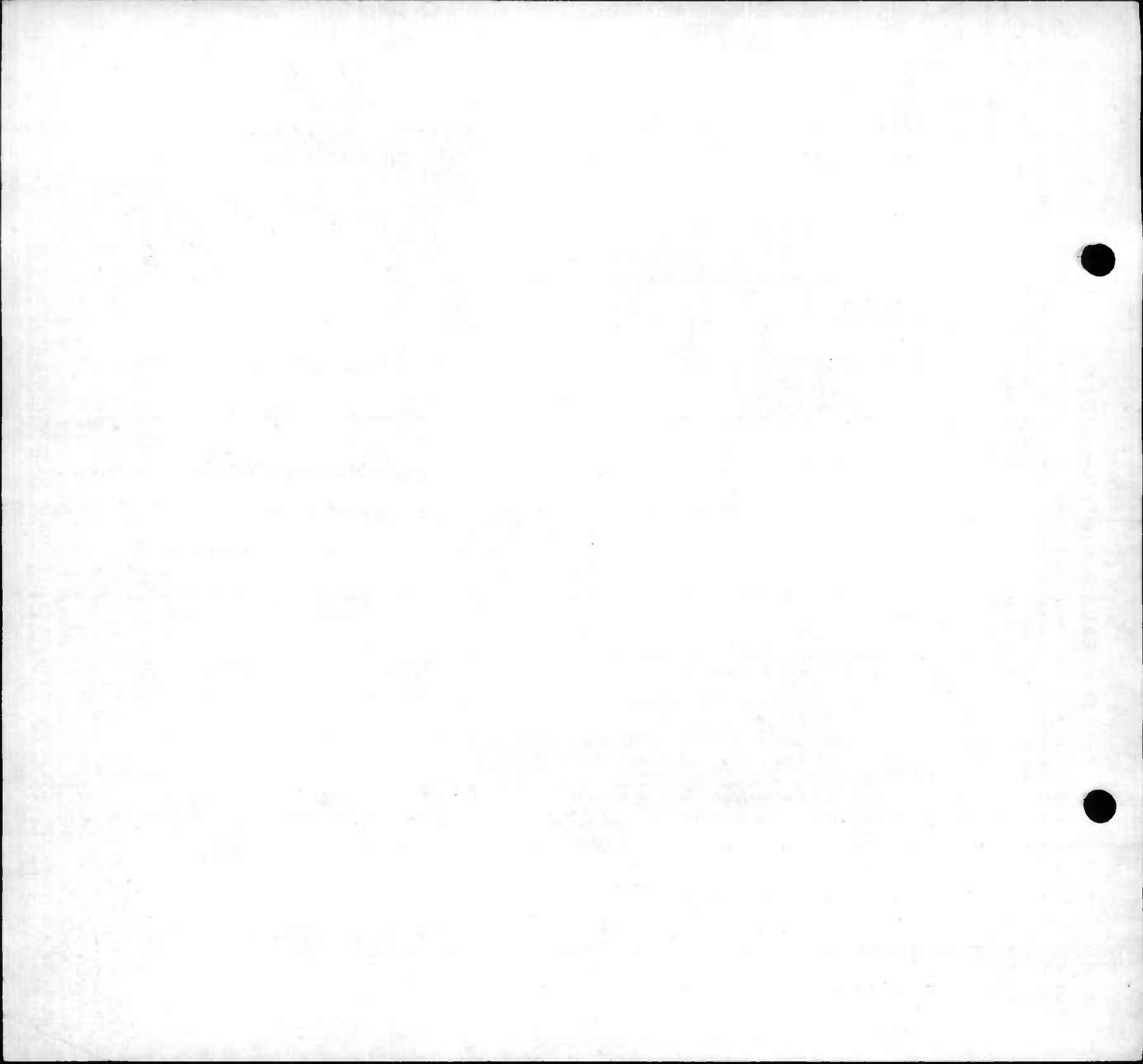
BIRTH NO. <u>66-922-28132</u> <u>6400</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>66 00901</u>	
M.E. CASE NO. <u>66 00901</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Brown, Stephanie</u>		2. DATE AND HOUR OF DEATH <u>1-24-66</u> <u>6:00</u> P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>33 THE JOHNS HOPKINS HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND, BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>RANDALLSTOWN</u> D. STREET ADDRESS (If rural, give location) <u>9818 KERRIGAN COURT</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>11-9-65</u>	9. AGE (In years last birthday) <u>2</u> <u>15</u>	If Under 1 Yr. Months: Days: Hours: Min. <u>2</u> <u>15</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <u>RAY BROWN</u>		14. MOTHER'S MAIDEN NAME <u>LORRAINE HOLEWENSKI</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr Ray C. Brown</u> ADDRESS <u>9818 Kerrigan Ct Randallstown</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cyanotic heart disease birth - 2mo</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>1-20</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Cyanotic heart disease</u>		20A. AUTOPSY (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1-20</u> 19 <u>66</u> to <u>1-24</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1-24-66</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Walter Smithwick</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1-24</u>	
23C. PHYSICIAN'S NAME (Type) <u>WALTER SMITHWICK 2ND</u>		23D. ADDRESS M.D. <u>THE JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>1/27/66</u>	24C. NAME of CEMETERY or CREMATORY <u>Balto. National</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 27 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Fink</u>		25C. FUNERAL DIRECTOR <u>Loring Beyers</u> ADDRESS <u>Randallstown, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 66 00902	
BIRTH NO. 65-20398		66 00902					
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) CHRISTINA GEORGE				1/21/66 3:00 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Mercy Hospital FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore, Md.				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY Balto.			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto.			
				D. STREET ADDRESS (If rural, give location) 1320 Highland Drive			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) infant	8. DATE OF BIRTH 8/13/65	9. AGE (In years last birthday) 5 8	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		10B. KIND OF BUSINESS OR INDUSTRY infant		11. BIRTHPLACE (State or foreign country) Balto		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Emanuel George				14. MOTHER'S MAIDEN NAME Irene Argyrakis			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. —		17. INFORMANT ADDRESS Mr. Emanuel George Same as #4	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO Aspiration of Vomitus 16 min (B) DUE TO Failure of normal devel 2° to a (C) Suspected CNS anomaly		INTERVAL BETWEEN ONSET AND DEATH	
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) None		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1/19 1966 to 1/21 1966, that (I) (we) last saw the deceased alive on 1/21 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE W.E. Schwartz				23B. DATE SIGNED 1/22/66			
23C. PHYSICIAN'S NAME (Type) W.E. SCHWARTZ				23D. ADDRESS Mercy Hospital, Balto			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan. 24 1966		24C. NAME OF CEMETERY OR CREMATORY Greek Orthodox Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1966		25B. NAME OF REGISTRAR Wm Cook - Bethesda Town		25C. FUNERAL DIRECTOR 1050 York Rd Towson, Md		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00903	
BIRTH NO. Fort Meade, Md. 66 00903				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) JACQUELINE MARGOT DOYLE				JAN. 25, 1966 8:50 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL				A. STATE Md. B. COUNTY ANNE ARUNDEL	
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) FT. G. G. MEADE 52-00	
				D. STREET ADDRESS (If rural, give location) 8011-C LESLIE ROAD	
5. SEX F	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) CHILD	8. DATE OF BIRTH 12-22-65	9. AGE (In years last birthday) 1 3	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10B. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JOHN H. DOYLE			14. MOTHER'S MAIDEN NAME MARIA BOWERS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT MOTHER		ADDRESS S/A
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE RESPIRATORY ARREST DUE TO AQUADUCTAL STENOSIS. DUE TO MENINGOMYELOCELE			CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH 15 min. 1 month 3 days		
19. DATE OF OPERATION 12/30 - 1/9 - 1/20			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED MENINGOMYELOCELE - INTRACRANIAL PRESSURE - CRANIOSYNOSTOSIS		
20A. AUTOPSY? (Yes or No) NO			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 12/30 1965 to 1/25 1966 that (1) (we) last saw the deceased alive on 1/25 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (Yes) (did) (did not) view the body after death.					
23A. SIGNATURE Ivan L. Butler				23B. DATE SIGNED 1/25/66	
23C. PHYSICIAN'S NAME (Type) IVAN L. BUTLER				23D. ADDRESS UNIVERSITY HOSPITAL Bldg. 1. MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 1/27/66		24C. NAME OF CEMETERY OR CREMATORY Cleversburg E U B	
24D. LOCATION (City, town, or county) (State) Shippensburg, Pennsylvania		25A. DATE REC'D BY HEALTH DEPT. JAN 27 1966			
25B. NAME OF REGISTRAR J. E. ...		25C. FUNERAL DIRECTOR Wm. J. ...			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
66 00904				CERTIFICATE OF DEATH		66 00904	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)			
				Juanita G Ross			
2. DATE AND HOUR OF DEATH				1. 24. 66 1:50 a. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
46 Lutheran Hospital				Maryland 15-04			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				Baltimore			
D. STREET ADDRESS (If rural, give location)				2130 Pulaski St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		
F	C	SINGLE	3-10-22	43			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Domestic		Pvt. Family		Baltimore Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Charles William Gross				Mary Duckett			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
				Ruth Neal-2130 N. Pulaski St.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
330X I				(A) DUE TO Subarachnoid hemorrhage			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11. 2265 19 to 1. 24 1966, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE F. Abbousy				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1. 24. 66	
23C. PHYSICIAN'S NAME (Type) Fadhil Abbousy				23D. ADDRESS Lutheran Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		1/28/66		Arbutus Memorial Pk.		Baltimore Co. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 27 1966		Herbert E. Nutter		Herbert E. Nutter-3035 W. North Ave.			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 00905BIRTH NO. 66 00905

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE W. DORSEY

2. DATE AND HOUR PRONOUNCED DEAD

January 21, 1966 11:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street
address or location)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1308 Stockton Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

12/29/23

9. AGE (In years
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George H. Dorsey Sr.

14. MOTHER'S MAIDEN NAME

Margaret Vesels

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

212-20-0042

17. INFORMANT

ADDRESS

Mrs Elsie Carr 1215 Woodington Rd. Apt 4A

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoporosis, etc. It means the disease,
injury or complication which caused death.)

Right Perineal Tuberculous Abscess.

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/21/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1/26/66

23C. NAME OF CEMETERY or CREMATORY

Mt Calvary Cemetery

23D. LOCATION

(City, town, or county)

(State)

Brooklyn, Maryland

24A. DATE REC'D BY HEALTH DEPT.

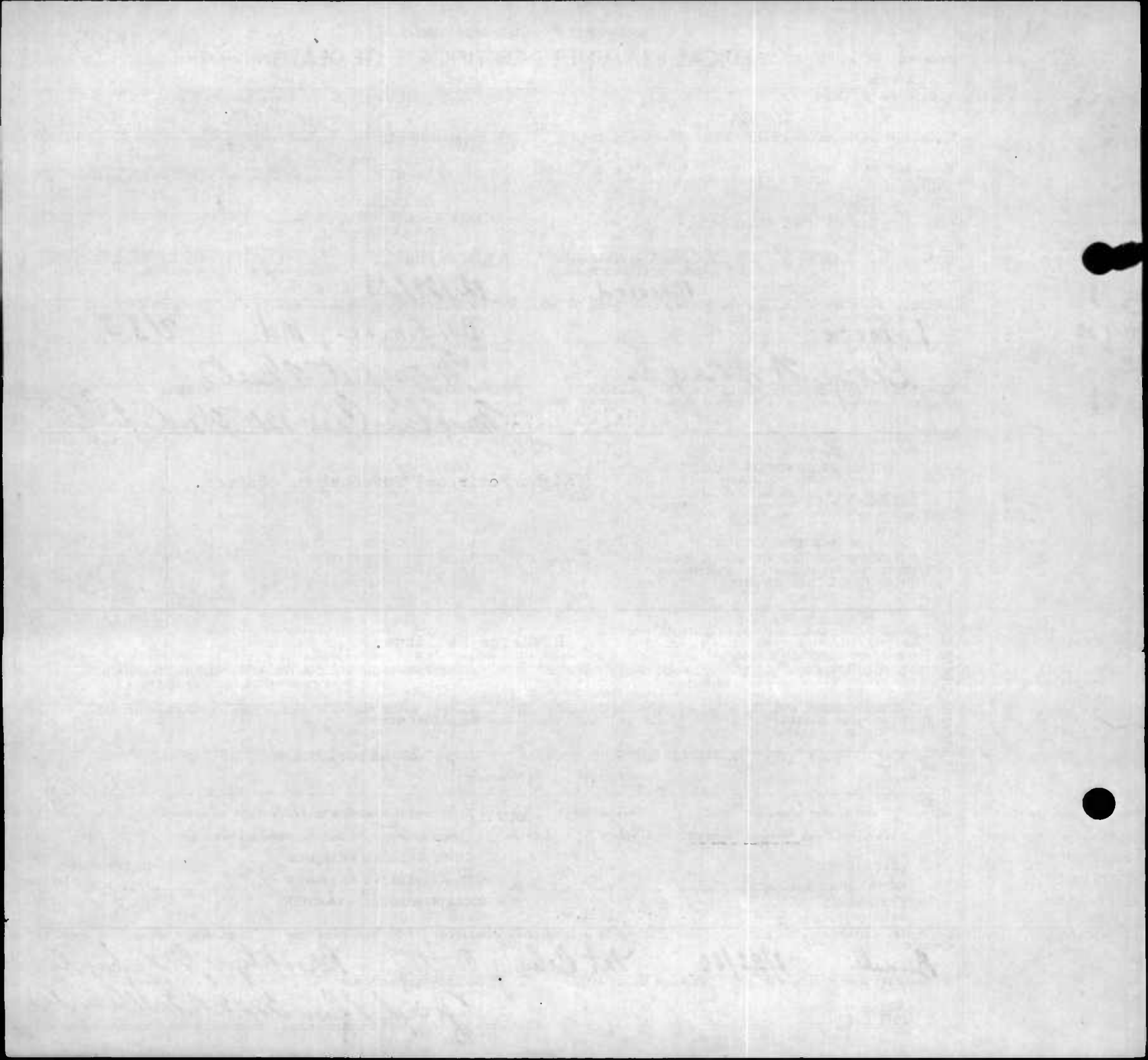
24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JAN 27 1966

Joseph L. Hess 2222 N. Wolfe Ave (16)



1

66 00906

BALTIMORE CITY HEALTH DEPARTMENT

66 00906

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED (Type or Print) Michael Irby

2. DATE AND HOUR PRONOUNCED DEAD 1/23/66 4:15 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY _____

5. SEX male 6. RACE colored 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married

8. DATE OF BIRTH Apr. 27, 1930 9. AGE (In years last birthday) 35

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 10B. KIND OF BUSINESS OR INDUSTRY Construction Co. 11. BIRTHPLACE (State or foreign country) South Carolina

12. CITIZEN OF WHAT COUNTRY? _____

13. FATHER'S NAME Cleveland Irby 14. MOTHER'S MAIDEN NAME Rosa Lee Boyd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no 16. SOCIAL SECURITY NO. 249-449091 17. INFORMANT Alvin Irby ADDRESS 1913 W. Franklin St.

18. CAUSE OF DEATH

(A) Hemorrhagic pancreatitis

(B) Empyema, left pleural cavity following gunshot wounds

(C) _____

INTERVAL BETWEEN ONSET AND DEATH _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. _____

19A. DATE OF OPERATION _____ 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20A. AUTOPSY? (Yes or No) yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. _____ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) house 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1912 W. Mulberry St.

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 1 20 66 7:00p. 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 21F. HOW DID INJURY OCCUR? shot several times

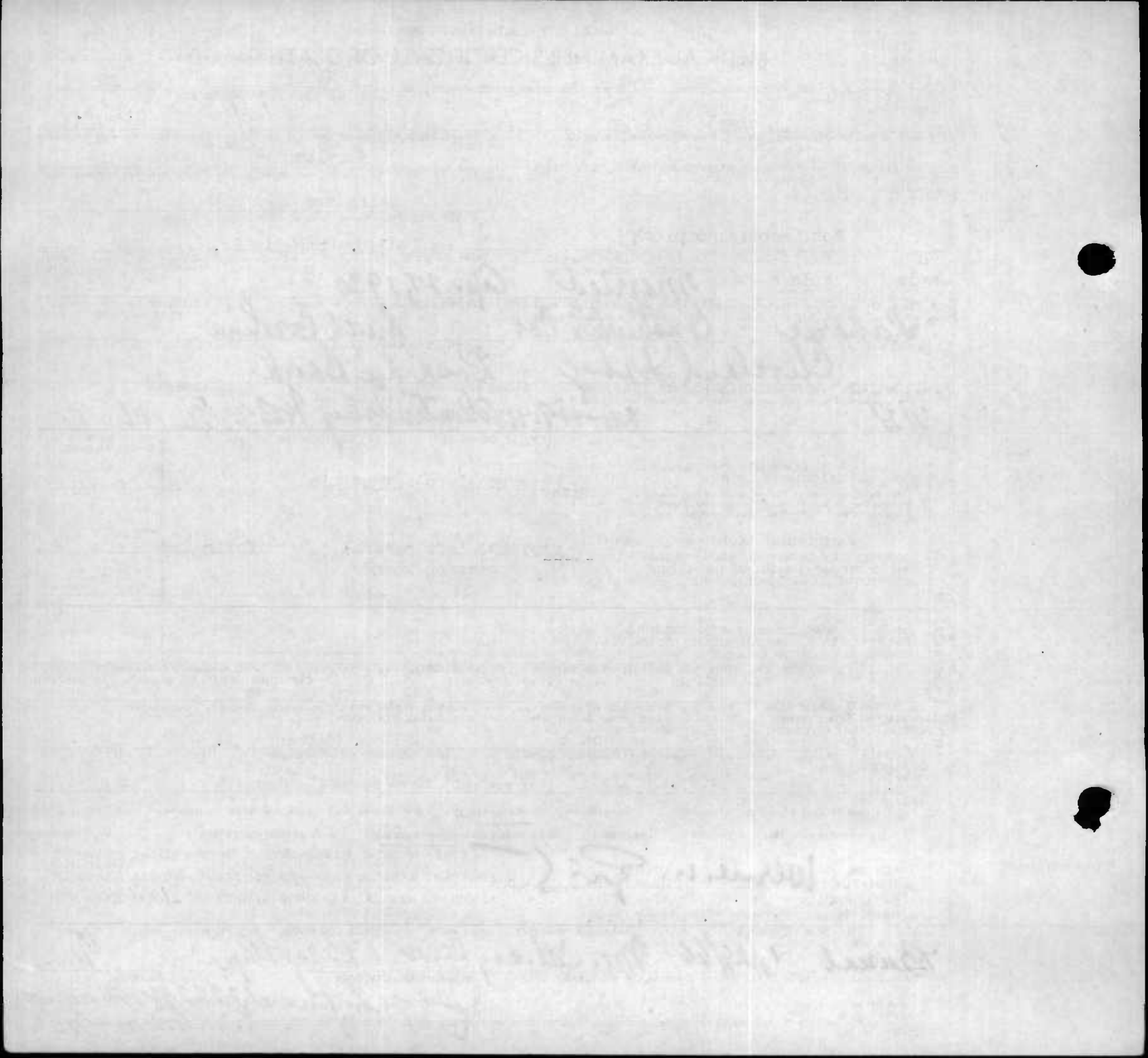
22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE Werner U. Spitz M.D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 1/23/66

EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 1/29/66 23C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem. 23D. LOCATION (City, town, or county) (State) Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT. JAN 27 1966 24B. NAME OF REGISTRAR Joseph L. Russ 24C. FUNERAL DIRECTOR 2222 W. Hanover ADDRESS Baltimore, Md.



THE BODY OF THOMAS MINOR WAS RELEASED ON APPROVAL BY DR. HIRSCH
OF THE MEDICAL EXAMINER'S OFFICE
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

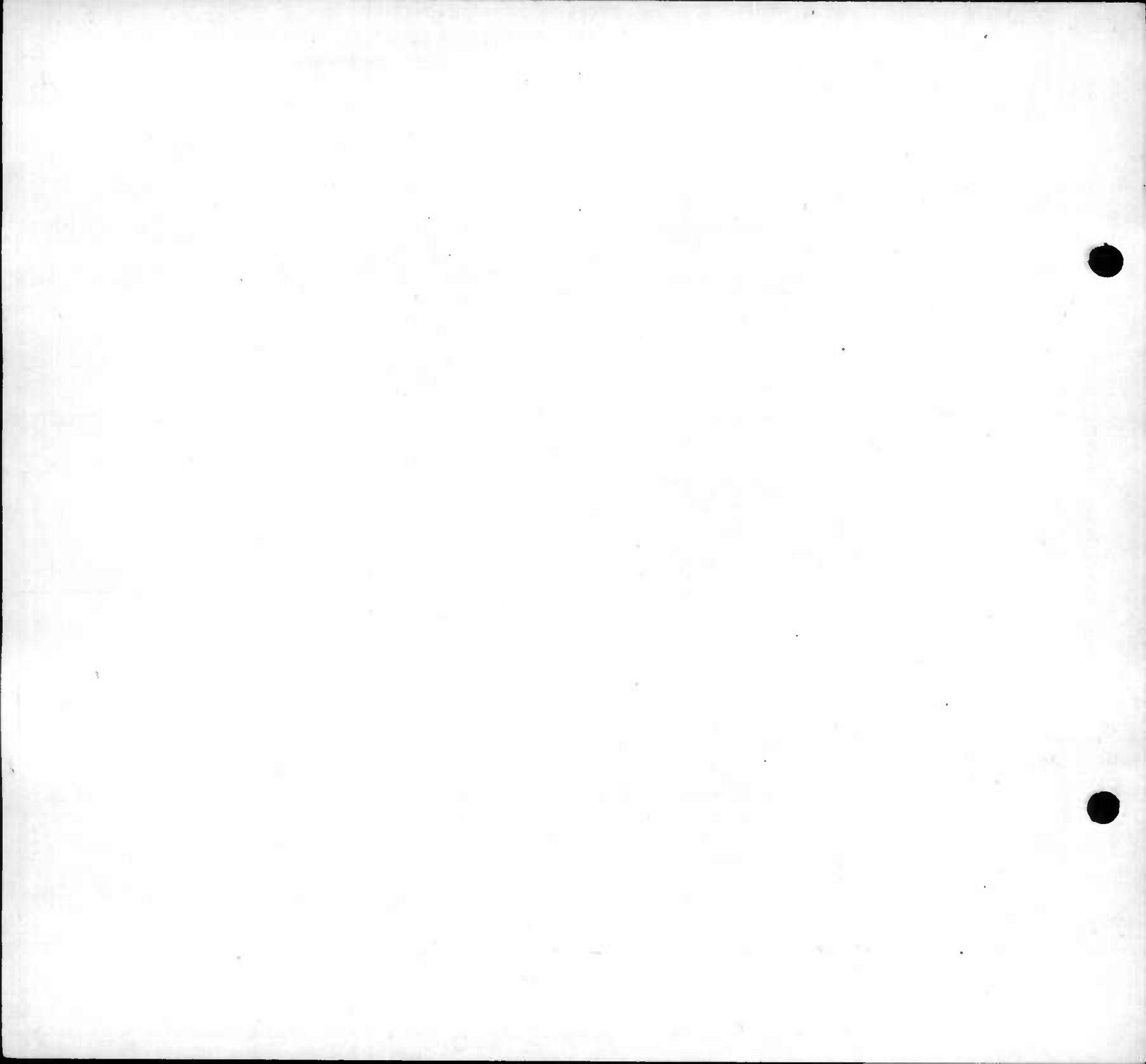
BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 66 00907					CERTIFICATE OF DEATH					Registered No. 66 00907				
1. NAME OF DECEASED (Type or Print) THOMAS MINOR					2. DATE AND HOUR OF DEATH 1-23-66 1855 P.M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 6-84					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				
D. STREET ADDRESS (If rural, give location) 21 N. DURHAM ST.					5. SEX MALE					6. RACE NEGROID				
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SEPARATED					8. DATE OF BIRTH 1-19-10					9. AGE (In years last birthday) 56				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer					10B. KIND OF BUSINESS OR INDUSTRY Steel Co.					11. BIRTHPLACE (State or foreign country) Danvers, Virginia				
12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME JAMES MINOR					14. MOTHER'S MAIDEN NAME EDNA WHITE				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO. 233-073502					17. INFORMANT Robert Minor 1800 Rutland Ave				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CLOSTRIDIAL INFECTION					INTERVAL BETWEEN ONSET AND DEATH ~ 3 1/2 wks									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. FOREIGN BODY					OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. HEART FAILURE									
19A. DATE OF OPERATIONS 1-3 IED					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED DEBRIDEMENT; ILEUS					20A. AUTOPSY? (Yes or No) NO				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 00-00				
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) <input type="checkbox"/>					21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR? <input type="checkbox"/>				
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from DECEMBER 31 19 65 to JANUARY 23 , 19 66 , that (I) was last saw the deceased alive on JANUARY 23 19 66 and that in (my) my opinion death occurred on the date and hour and from the causes stated above. (I) was (did) <input checked="" type="checkbox"/> view the body after death.														
23A. SIGNATURE Don Eugene Detmer					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED 1-23-66				
23C. PHYSICIAN'S NAME (Type) DON EUGENE EUGENE DETMER					23D. ADDRESS JOHNS HOPKINS HOSP, BALTO MD.									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 1-30-66					24C. NAME OF CEMETERY or CREMATORY Saint Mark Cemetery				
24D. LOCATION (City, town, or county) (State) Danvers, Va.					25A. DATE REC'D BY HEALTH DEPT. JAN 27 1966					25B. NAME OF REGISTRAR Paul J. Tolson				
25C. FUNERAL DIRECTOR Randolph J. Collick					ADDRESS 1425 E. Preston St.									

THE UNIVERSITY OF MICHIGAN
LIBRARY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

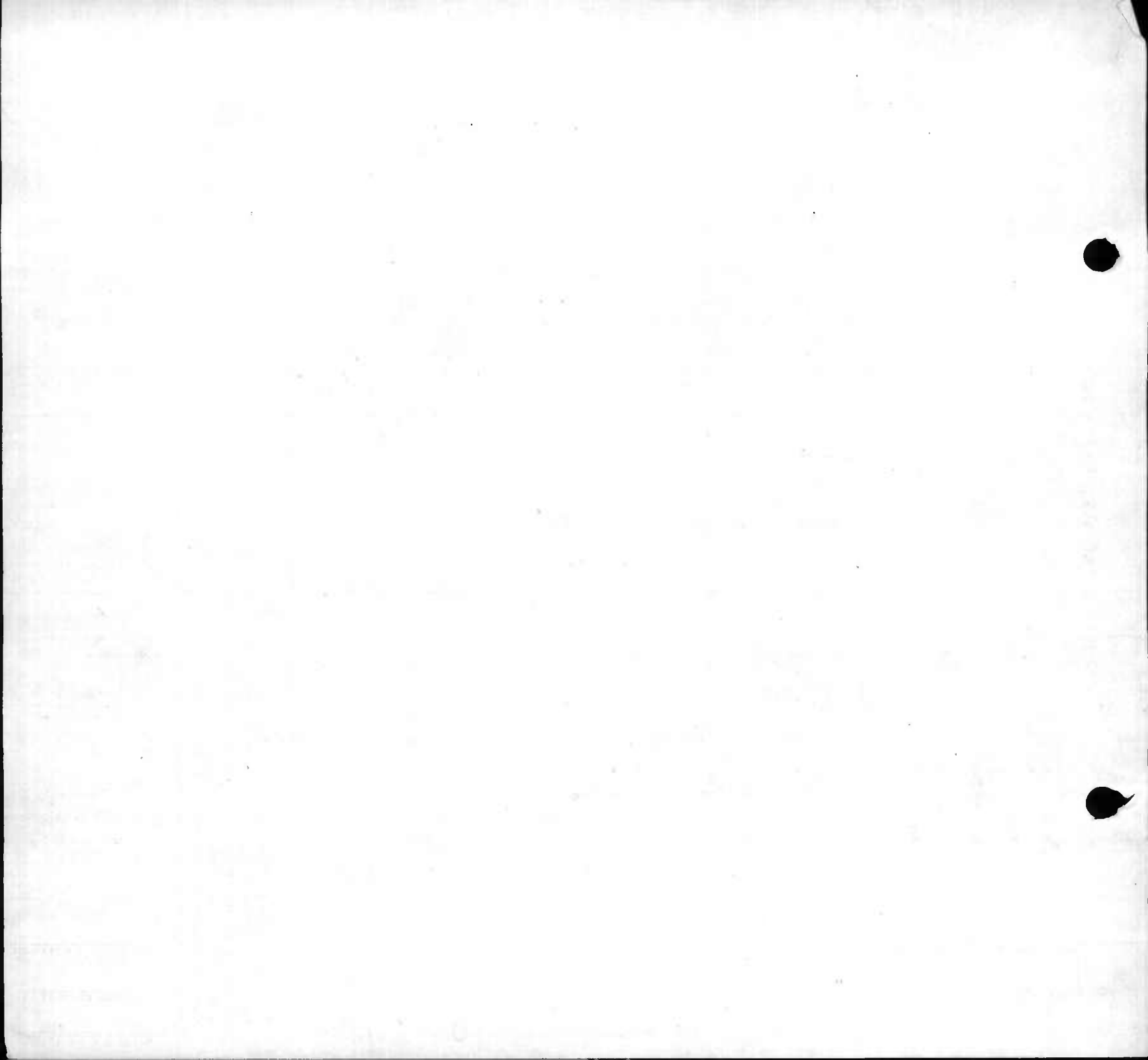
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 00908					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 66 00908				
1. NAME OF DECEASED (Type or Print) ALFONZO LEE HUDGINS					2. DATE AND HOUR OF DEATH 1-25-66 1:30 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 6 FRANKLIN SQUARE HOSPITAL					A. STATE MARYLAND B. COUNTY 16-06				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 16				
					D. STREET ADDRESS (If rural, give location) 715 ASH BURTON ST				
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE			8. DATE OF BIRTH 12/29/23	9. AGE (In years last birthday) 42	10. Under 1 Yr. Months: Days: Hours: Min.		11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PATTERN MAKER					10B. KIND OF BUSINESS OR INDUSTRY HFG. CO.				
11. BIRTHPLACE (State or foreign country) VIRGINIA					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME NORMAN BILLUPS					14. MOTHER'S MAIDEN NAME SARAH HUDGINS				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO ?					16. SOCIAL SECURITY NO. 217-20-1872				
17. INFORMANT MEDICAL RECORDS					ADDRESS				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 5-92X I Uremia					INTERVAL BETWEEN ONSET AND DEATH 2 weeks				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) DUE TO chronic glomerulonephritis 1 1/2 years				
(B) DUE TO					(C) DUE TO				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 1-20 19 66 to 1-25 19 66, that (I) (we) last saw the deceased alive on 1-25 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE J. V. de Boria					23B. DATE SIGNED 1-25-66				
23C. PHYSICIAN'S NAME (Type) JACINTO V. DE BORJA M.D.					23D. ADDRESS FRANKLIN SQ. HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 1/25/66				
24C. NAME of CEMETERY or CREMATORY Mt Auburn					24D. LOCATION (City, town, or county) (State) Baltimore Md				
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1966					25B. NAME OF REGISTRAR Robert E. [unclear]				
25C. FUNERAL DIRECTOR Marshall P. [unclear]					25D. ADDRESS 638 N 616 mor St				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00909		CITY HEALTH DEPARTMENT		Registered No. 66 00909	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Leo Burgess		2. DATE AND HOUR OF DEATH Jan 25 1966 2:58 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION University Hospital		A. STATE Md. B. COUNTY Baltimore City			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 636 N. Gilmore St.			
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 4/4/10	9. AGE (In years last birthday) 55	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe fitter		10B. KIND OF BUSINESS OR INDUSTRY Sewage Dept.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Burgess		14. MOTHER'S MAIDEN NAME Mary Stewart			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT ADDRESS hospital records	
18. 420.11		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO pulmonary edema		18 hrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) myocardial infarction		8 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (he) (this hospital) attended the deceased from 17 Jan 1966 to 25 Jan 1966 , that (he) (we) lost saw the deceased alive on 25 Jan 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (He) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Susan L. Howard, M.D.				23B. DATE SIGNED 25 Jan 1966	
23C. PHYSICIAN'S NAME (Type) M.D.		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Buried		24B. DATE 1/28/66		24C. NAME OF CEMETERY or CREMATORY MT Auburn	
24D. LOCATION (City, town, or county) (State) Baltimore Md					
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1966		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR ADDRESS 638 N Gilmore St	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

George W. Evans Jr. III

2. DATE AND HOUR PRONOUNCED DEAD

1/25/66 10:32 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3110 Normount Ave.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Never Married

8. DATE OF BIRTH

Nov. 21, 1951

9. AGE (In years
last birthday)

14

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

George W. Evans Jr.

14. MOTHER'S MAIDEN NAME

Ann Dillard

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

George W. Evans Jr. 3110 Normount Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot wound of chest, involving
heart and both lungs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

3110 Normount Ave.

21D TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
1 25 66 10:00a.m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

shot while playing with pistol.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/25/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1/25/66

23C. NAME OF CEMETERY or CREMATORY

Balto. Natl. Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

JAN 27 1966

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Never handled

Belgium, 1941

and others

Belgium, 1941

Belgium, 1941

Belgium, 1941

Belgium, 1941

Belgium, 1941

Belgium, 1941

Belgium, 1941

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED
(Type or Print)

PARISH SINKLER

2. DATE AND HOUR PRONOUNCED DEAD

January 19, 1966

6:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

MARYLAND GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

710 Druid Hill Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married (Sep)

8. DATE OF BIRTH

Feb 11, 1908

9. AGE (In years
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

S. C.

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Sophia

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Eva Sinkler 1816 Lorman St

18. E982X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Stab wound of leg
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

House

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

710 Druid Hill Avenue

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
1 19 66 5:30 P.M.
and 6:15 P.M.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Stabbed during altercation

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-20-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1-26-66

23C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JAN 27 1966

Robert J. Faden

1316 N. Calhoun St

WALLLEY-BORCE

RECEIVED

1964
JUN 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 66 00912					CERTIFICATE OF DEATH					Registered No. 66 00912				
1. NAME OF DECEASED (Type or Print) JAMES DONAHUE					2. DATE AND HOUR OF DEATH 1-26-66 4:00 P.M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION #2 Sinai Hospital of Baltimore					A. STATE Maryland B. COUNTY Baltimore					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
					D. STREET ADDRESS (If rural, give location) 8216 Harris Ave. #34									
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH JUNE 26, 1926		9. AGE (In years last birthday) 39		10. If Under 1 Yr. Months Days		11. If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, specify if retired) Asst. Regional Mgr. METROPOLITAN LIFE INSURANCE CO.					10B. KIND OF BUSINESS OR INDUSTRY Phila. PENNA.					12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME James H. Donahue					14. MOTHER'S MAIDEN NAME Elva Hess									
15. Was Deceased Ever in U. S. Armed Forces? (Yes/no or unknown) (If yes, give war or dates of service) Yes WWII					16. SOCIAL SECURITY NO.					17. INFORMANT JEAN R. DONAHUE				
					ADDRESS 8216 HARRIS AVE. BALTIMORE, Md.									
18. CAUSE OF DEATH 42.0.1 I					DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)					INTERVAL BETWEEN ONSET AND DEATH				
					(A) DUE TO Myocardial Insufficiency					2 Days				
					(B) DUE TO Acute Myocardial Infarction					7 days				
					(C) Arteriosclerotic Cardiovascular Disease					45 years				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					II Pass. pneumonia									
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 1-20 19 66 to 1-26 19 66 , that (I) (we) last saw the deceased alive on 1-26 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE Rodelio M. Lim										23B. DATE SIGNED 1-26-66				
23C. PHYSICIAN'S NAME (Type) RODELIO M. LIM										23D. ADDRESS Sinai Hospital of Baltimore				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL					24B. DATE 1-29-66					24C. NAME OF CEMETERY or CREMATORY Holy Sepulchre				
24D. LOCATION (City, town, or county) (State) WYNDMOOR MNTG. PENNA					25A. DATE REC'D BY HEALTH DEPT. JAN 27 1966					25B. NAME OF REGISTRAR Leonard J. Ruck, Inc. BALTIMORE, Md.				
25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. BALTIMORE, Md.					25D. ADDRESS									

Summit June 21/18 89

1894

Illustrated Life Insurance Co. Phila. Penna

James H. Denham

Box 1111

from R. Denham

Personal property

and fixtures

of the estate of James H. Denham

deceased

and the same

being the same

as the same

as the same

as the same

as the same

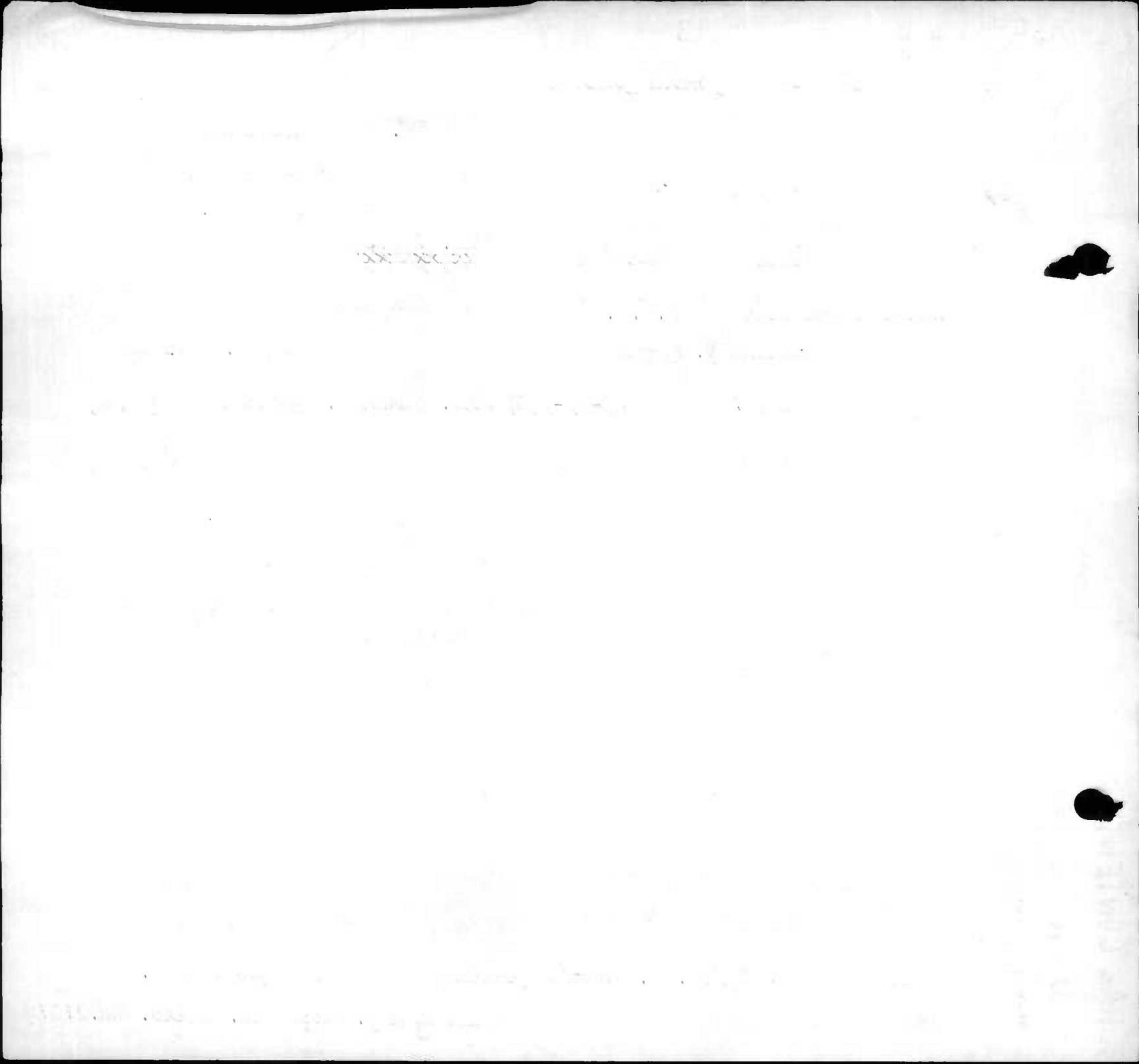
as the same

as the same

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

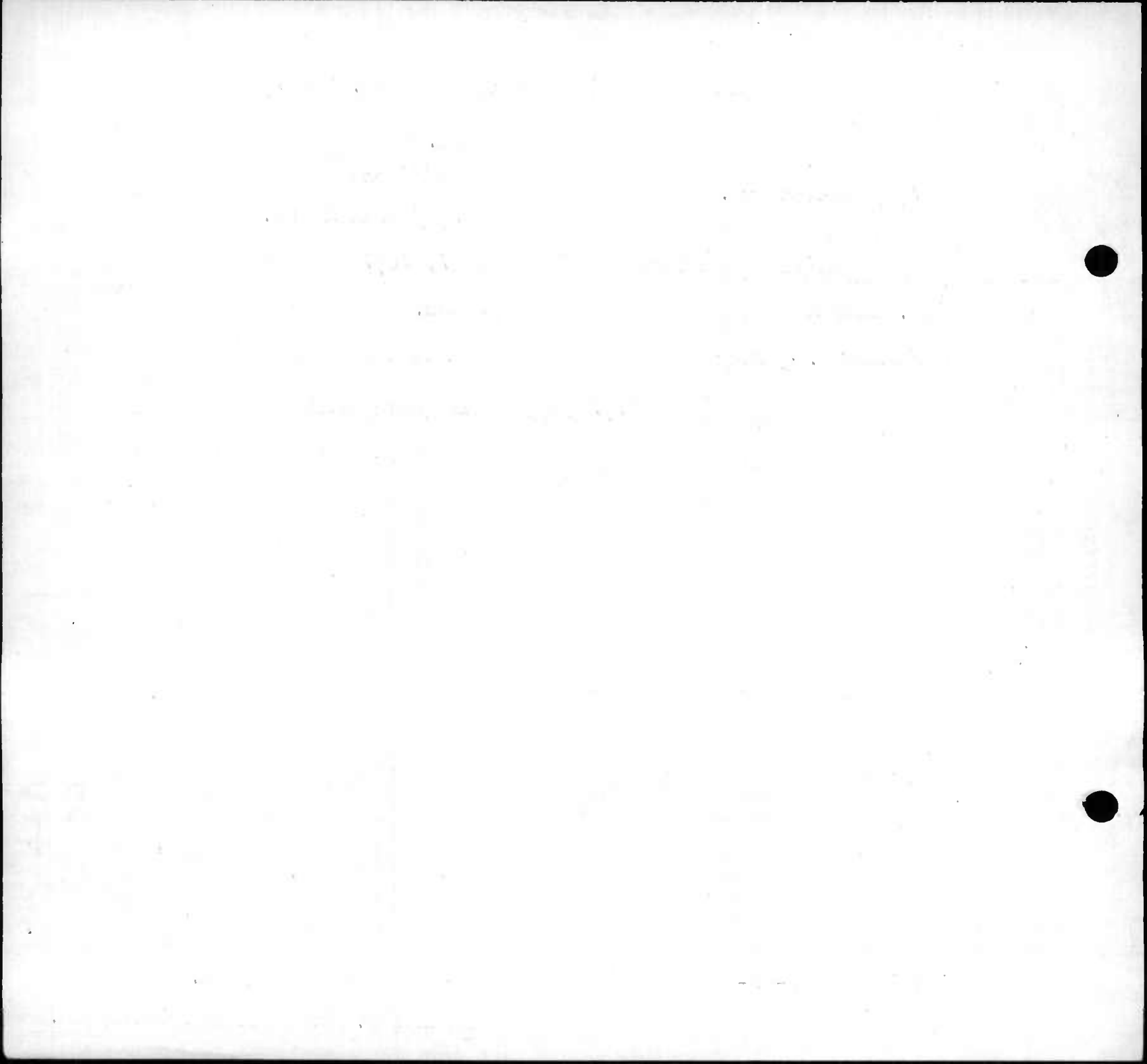
BALTIMORE CITY HEALTH DEPARTMENT											
BIRTH NO. 66 00913						CERTIFICATE OF DEATH					
M.E. CASE NO.						Registered No. 66 00913					
1. NAME OF DECEASED (Type or Print) <i>Francis Edward Cochran</i>						2. DATE AND HOUR OF DEATH <i>1-26-66</i> <i>1:05</i> A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <i>87 Mercy Hospital</i>						A. STATE <i>Md.</i> 8. COUNTY <i>Baltimore</i>					
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #4</i>						D. STREET ADDRESS (If rural, give location) <i>235 Burke Ave.</i>					
5. SEX <i>Male</i>		6. RACE <i>White</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>		8. DATE OF BIRTH <i>Oct. 19, 1893</i>		9. AGE (In years last birthday) <i>72</i>		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Train Dispatcher</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>P.R.R.</i>				11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>						13. FATHER'S NAME <i>William J. Cochran</i>					
14. MOTHER'S MAIDEN NAME <i>Mary J. Bradley</i>						15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WW I</i>					
16. SOCIAL SECURITY NO. <i>717-07-7907</i>						17. INFORMANT <i>Mrs. Sarah A. Cochran</i>					
18. CAUSE OF DEATH						INTERVAL BETWEEN ONSET AND DEATH					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>420.1 I</i>						(A) <i>myocardial INFARCTION</i> DUE TO					
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(B) <i>CORONARY THROMBOSIS</i> DUE TO					
18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>II</i>						(C) <i>Arteriosclerosis</i>					
19A. DATE OF OPERATION <i>4-20-61</i>						19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Peripheral vascular Insufficiency</i>					
20A. AUTOPSY? (Yes or No) <i>No</i>						20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>						21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						21F. HOW DID INJURY OCCUR?					
22. I certify that (1) <i>this hospital</i> attended the deceased from <i>Jan. 22</i> 19 <i>66</i> to <i>Jan. 26</i> 19 <i>66</i> , that (1) <i>we</i> last saw the deceased alive on <i>Jan. 26</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>Isabelita Cordoba</i>						23B. DATE SIGNED <i>1/26/66</i>					
23C. PHYSICIAN'S NAME (Type) <i>ISABELITA CORDOBA</i>						23D. ADDRESS <i>Mercy Hospital, Balto. 2, Md.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>1/29/66</i>				24C. NAME OF CEMETERY or CREMATORY <i>St. John's Cemetery</i>			
24D. LOCATION (City, town, or county) (State) <i>Long Green, Md.</i>				25A. DATE REC'D BY HEALTH DEPT. <i>JAN 27 1966</i>				25B. NAME OF REGISTRAR <i>Robert E. Fairman</i>			
25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc.</i>				25D. ADDRESS <i>Balto. Md. 21214</i>				25E. DATE REC'D BY HEALTH DEPT. <i>JAN 27 1966</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

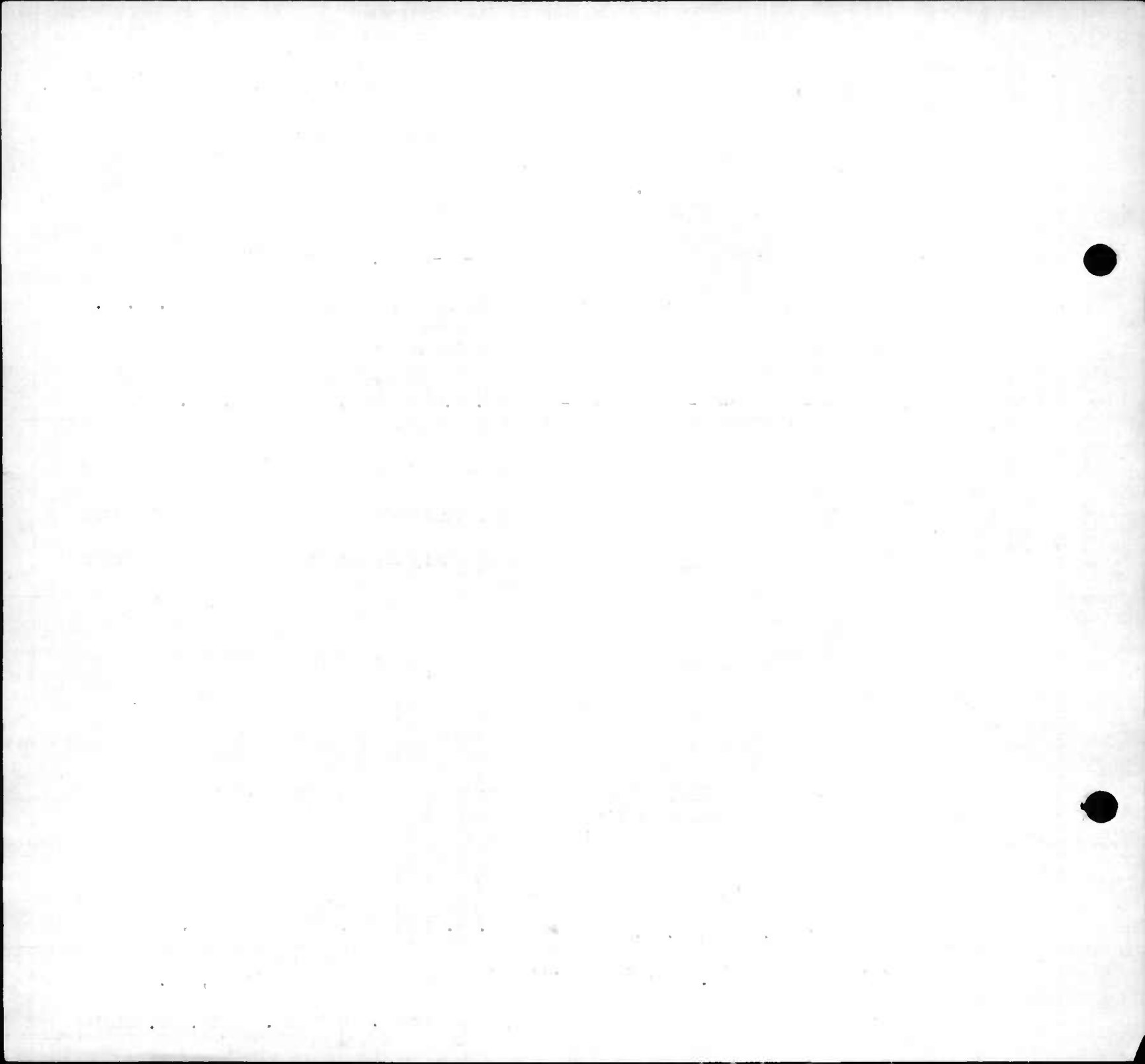
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO.		66 00914		CERTIFICATE OF DEATH		Registered No. 66 00914	
1. NAME OF DECEASED (Type or Print)				Charles William Cooney				2. DATE AND HOUR OF DEATH Jan. 26, 1966 12:30 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				A. STATE Md.			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				1427 Walker Ave.				B. COUNTY 27-38			
5. SEX male				6. RACE white				7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed			
8. DATE OF BIRTH May 1, 1891				9. AGE (In years last birthday) 74				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Barber			
11. BIRTHPLACE (State or foreign country) Penna.				12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME William P. Cooney			
14. MOTHER'S MAIDEN NAME Alice Harrison				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 219125843			
17. INFORMANT Mrs Edith Nott				18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Coronary Occlusion				INTERVAL BETWEEN ONSET AND DEATH 10 years			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				20. CAUSE OF DEATH (A) DUE TO Coronary Atherosclerosis (B) DUE TO Myocardial Infarction (C) DUE TO CVD				21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
22. I certify that (I) (this hospital) attended the deceased from January 20, 1966 to January 26, 1966, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23. SIGNATURE Melvin F. Polek				23B. DATE SIGNED January 27, 1966			
24. BURIAL CREMATION, REMOVAL (Specify) burial				24B. DATE 1-31-66				24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery			
24D. LOCATION Baltimore, Md.				25A. DATE REC'D BY HEALTH DEPT. JAN 27 1966				25B. NAME OF REGISTRAR Leonard J. Ruck			
25C. FUNERAL DIRECTOR Inc Baltimore, Md.				25D. ADDRESS 3603 Belair Rd. Balto. Md 21213				25E. ADDRESS 3603 Belair Rd. Balto. Md 21213			



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00915	
66 00915				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) WAGNER, George Henry				January 26, 1966 4:15 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218			A. STATE Maryland B. COUNTY Baltimore		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 2911 White Avenue		
5. SEX Male	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4-20-28 98.	9. AGE (In years lost birthday) 38 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10B. KIND OF BUSINESS OR INDUSTRY Steel Mills		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME George Wagner			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
14. MOTHER'S MAIDEN NAME Effie Taylor			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 5-3-18 to 7-12-19		
16. SOCIAL SECURITY NO. 219-01-1619			17. INFORMANT Records ADDRESS V. A. Hospital, Baltimore, Md. 21218		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Pulmonary Edema				INTERVAL BETWEEN ONSET AND DEATH 24 hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cor Pulmonale				2 years	
(C) Pulmonary Emphysema				10 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 13 19 66 to January 26 19 66 , that (we) last saw the deceased alive on January 26 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John S. Howe M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 1/27/66	
23C. PHYSICIAN'S NAME (Type) JOHN S. HOWE, M. D.				23D. ADDRESS V. A. Hospital, Baltimore, Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/31/66.		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1966		25B. NAME OF REGISTRAR Leonard J. Ruck Inc.		25C. FUNERAL DIRECTOR ADDRESS Balto. Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 66 00916		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00916	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) DAVID SOURS GRAHAM SR.			JANUARY 25, 1966 4 30 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION University of Maryland Hospital (If not in hospital or institution, give street address or location)			A. STATE Md. B. COUNTY		
5. SEX MALE			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
6. RACE WHITE			Annapolis 52-10		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED			D. STREET ADDRESS (If rural, give location)		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agent			314 Severn Avenue		
10B. KIND OF BUSINESS OR INDUSTRY Ret.			8. DATE OF BIRTH 12-5-97		
11. BIRTHPLACE (State or foreign country) Penna.			9. AGE (In years last birthday) 68		
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME HERBERT S. Graham		
14. MOTHER'S MAIDEN NAME FRANCES SOWERS			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS Hospital Record		
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) Thrombosis of (1) Middle Cerebral Artery 12-28-91-25 28 Days (B) Cerebral Arteriosclerosis (C) Lobar Pneumonia		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) No			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (this hospital) attended the deceased from 12/28 1965 to 1/25 1966, that (we) lost saw the deceased alive on Jan 25 1966 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.					
23A. SIGNATURE John W. Tidwell, Jr.			23B. DATE SIGNED 1-25-66		
23C. PHYSICIAN'S NAME (Type) John William Tidwell, Jr.			23D. ADDRESS University Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 1-27-66		
24C. NAME OF CEMETERY or CREMATORY Hillcrest			24D. LOCATION (City, town, or county) (State) Annapolis MD.		
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1966			25B. NAME OF REGISTRAR Robert E. Selman		
25C. FUNERAL DIRECTOR John M. Taylor & Sons			25D. ADDRESS Annapolis, MD.		

HERBERT

I

Get

8

7

FRANCIS J. JONES

FRANCIS J. JONES
HERBERT
JONES

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 66 00917

BIRTH NO. 66 00917

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Hennessey, Mary

2. DATE AND HOUR OF DEATH

January 25, 1966 3:30 a. m.

3. PLACE OF DEATH

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

Bolton Hill Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 8. COUNTY

513 N. Pulaski St. Md

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore 20-01

D. STREET ADDRESS (If rural, give location)

513 N. Pulaski St

5. SEX

F

6. RACE

W

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

8/15/82

9. AGE (In years
last birthday)

83

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Ireland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Thomas McQuigge

14. MOTHER'S MAIDEN NAME

Catherine Donahue

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

-

16. SOCIAL SECURITY NO.

-

17. INFORMANT

Hennessey James Hennessey 513 N. Pulaski St.

ADDRESS

18. *450,01*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) *generalized arteriosclerosis*

several yrs.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

degenerative changes in bones

several years

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from *1-5-66* 19 to *1-25-66* 19, that (I) (we) last saw the deceased alive on *1-24-66* 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

E. Ellsworth Cook

M.D.

Attending Phys.

☒

Med. Director

☐

Staff Phys.

☐

23B. DATE SIGNED

1-25-66

23C. PHYSICIAN'S NAME (Type)

E. Ellsworth Cook

23D. ADDRESS

M.D.

2431 Maryland Ave. Balto. Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1-28-66

24C. NAME OF CEMETERY or CREMATORY

Loudon Park Cem.

24D. LOCATION

(City, town, or county)

BALTO - Md

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 27 1966

25B. NAME OF REGISTRAR

Clifford E. ...

25C. FUNERAL DIRECTOR

Thomas J. Kenny Inc 1600 Collins St

ADDRESS

J-250

66 00918

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 00918

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HELEN JACKSON

2. DATE AND HOUR PRONOUNCED DEAD

January 19, 1966

8:10 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

MARYLAND GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

748 Pennsylvania Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

DIVORCED

8. DATE OF BIRTH

1-12-1929

9. AGE (In years
last birthday)

37

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

GREENVILLE, S.C.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

JAMES Robert Richardson

14. MOTHER'S MAIDEN NAME

EVELYNA Cobb

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

DAVID HARVEY 2512 Hollins St.

18.

490X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Lobar pneumonia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Fatty liver

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-20-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

REMOVAL-BURIAL

1-29-66

GREENVILLE Cemetery

Greenville, S.C.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JAN 27 1966

Robert E. Farley, M.D.

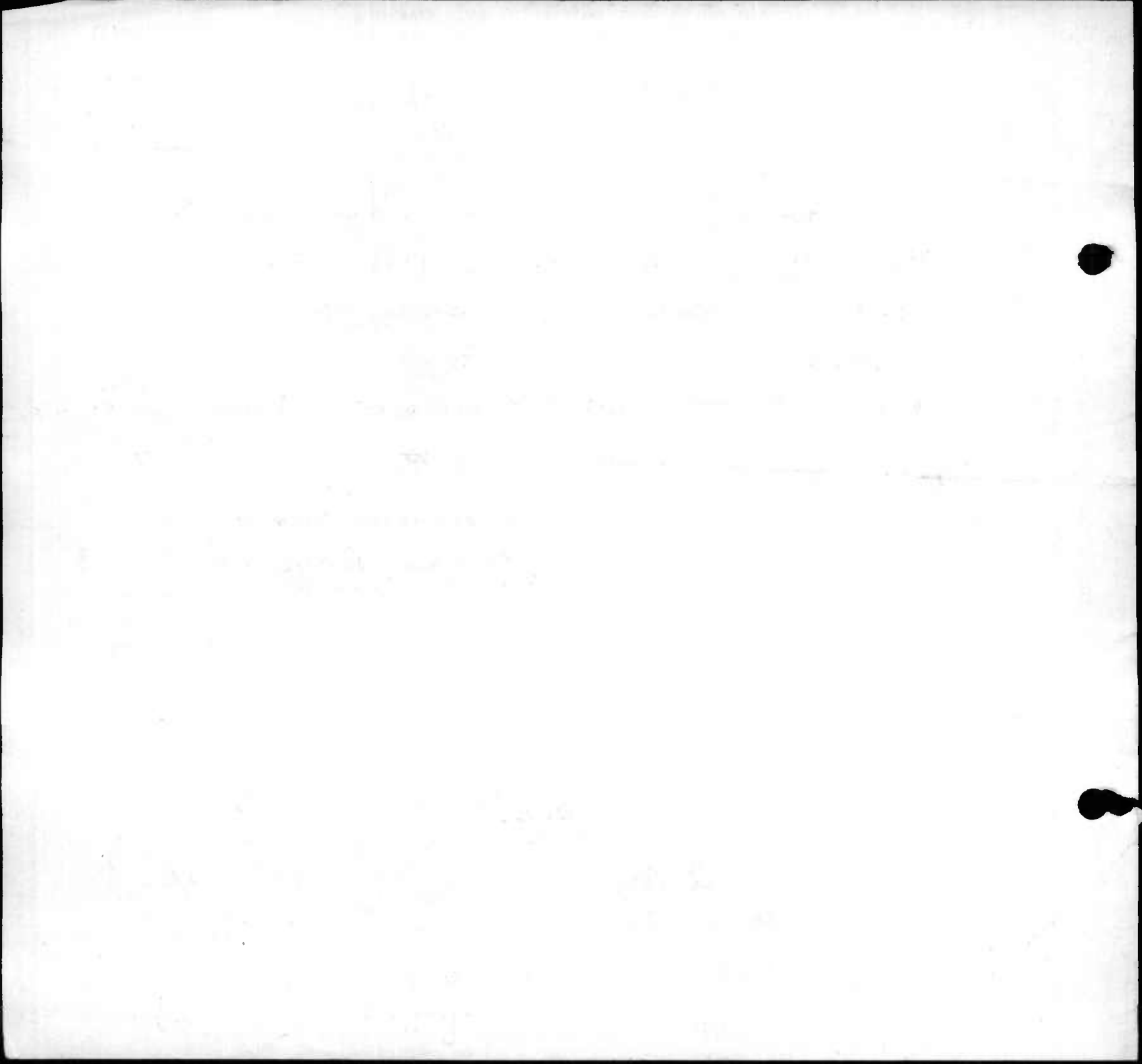
Marshall W. Jones, JR. 1735 HARFORD
AVE.

VALLEY FORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00919		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00919	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BARNETT- HOWARD (HYMAN)		2. DATE AND HOUR OF DEATH 1/26/66 7:35 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) A. STATE MD B. COUNTY 27-17			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LEVINSON - HERREN - HOME - AND - INFIRMARY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) BLU & GARDEN SPRING AVE			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) DIVORCED	8. DATE OF BIRTH 1894	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret		10B. KIND OF BUSINESS OR INDUSTRY COOK		11. BIRTHPLACE (State or foreign country) BALTO, MD	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JOHN		14. MOTHER'S MAIDEN NAME BELLE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 111-07-0275A		17. INFORMANT HORTENSE HOFFMAN	
				ADDRESS 2502 OAKLEY AVE	
18. 260X I		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Possible Myocardial Infarction			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) BRONCHOPNEUMONIA -			
		(C) POSSIBLE - SEPTICEMIA DIAPYCNES - HELLITUS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/14/58 19 to 1/26/66 19, that (I) (we) last saw the deceased alive on 1/26/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Aron Ary		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/26/66	
23C. PHYSICIAN'S NAME (Type) ARON ARY		M.D. ADDRESS SINAI HOSPITAL OF BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/28/66		24C. NAME OF CEMETERY or CREMATORY Hebrew Friendship	
				24D. LOCATION (City, town, or county) (State) Balto Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 27 1966		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Sylvan S. Lewis & Son, Inc	
				ADDRESS 3319 olympic ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 66 00920				
BIRTH NO. 66 00920					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) Weldon Floyd Thamma					2. DATE AND HOUR OF DEATH January 26-66 10 45 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Union Memorial Hospital FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 26-03				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
					D. STREET ADDRESS (If rural, give location) 3603 Brehms Lane				
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED Married	8. DATE OF BIRTH 4/7/93	9. AGE (In years last birthday) 72ys	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus Driver			10B. KIND OF BUSINESS OR INDUSTRY Transit System		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Walter Leonard Thamma					14. MOTHER'S MAIDEN NAME Flora Alberta Gilbert				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 215-09-3683		17. INFORMANT ADDRESS Bessie Thamma, wife, above				
18. 4 20, 1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction (A) DUE TO					INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coronary atherosclerosis, severe (B) DUE TO Pulmonary Pleural effusion, bilateral (C)									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Spots N/A									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that the (this hospital) attended the deceased from 11/23/66 to 1/26/66 , that we (we) last saw the deceased alive on 1/26/66 and that in our (our) opinion death occurred on the date and hour and from the causes stated above. (We) (We) (did) (did not) view the body after death.									
23A. SIGNATURE H. Brown					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/26/66		
23C. PHYSICIAN'S NAME (Type) HARRY BROWN					23D. ADDRESS M.D. UNION MEMORIAL HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/29/66		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 28 1966		25B. NAME OF REGISTRAR Carol E. Johnson		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 3331 Brehms Lane #13			

Handwritten text, possibly a signature or name, appearing upside down.

ALL THE WAY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00921	
BIRTH NO. 66 00921		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Crowley, Mr. Jule S.		2. DATE AND HOUR OF DEATH Jan-26-66 1+25 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 26-34 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5174 Wright Avenue			
5. SEX M	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4-8-19	9. AGE (In years last birthday) 46	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Checker		10B. KIND OF BUSINESS OR INDUSTRY Spector Freight System		11. BIRTHPLACE (State or foreign country) S. Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Stafford Crowley		14. MOTHER'S MAIDEN NAME Alice Moore			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes Army WW 2		16. SOCIAL SECURITY NO. 245-14-0938		17. INFORMANT Ann Minozzi Crowley, wife, above chart	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 454X1 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) FIBRINOUS PERITONITIS		CAUSE OF DEATH (A) DUE TO GANGRENE of Small Bowel (B) DUE TO Postoperative Adhesions (C) Electrolyte Imbalance		INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II					
19A. DATE OF OPERATION 1-26-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED obstruction of RT. femoral Ar. & intestinal		20A. AUTOPSY? (Yes or No) obst. - yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan-9 19 66 to Jan-26 19 66 , that (I) (we) last saw the deceased alive on Jan 26 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. Aillon		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Alejandro J. Aillon		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/29/66		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. JAN 28 1966		25B. NAME OF REGISTRAR Robert J. Taylor		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.	
25D. ADDRESS 3331 Brehms Lane					

Electrical Installation
Postoperative Address
Census of Small Towns
Fibrous Portland

2 - 100-12-10 2 - 100-12-10 2 - 100-12-10 2 - 100-12-10

100-12-10 2 - 100-12-10

①

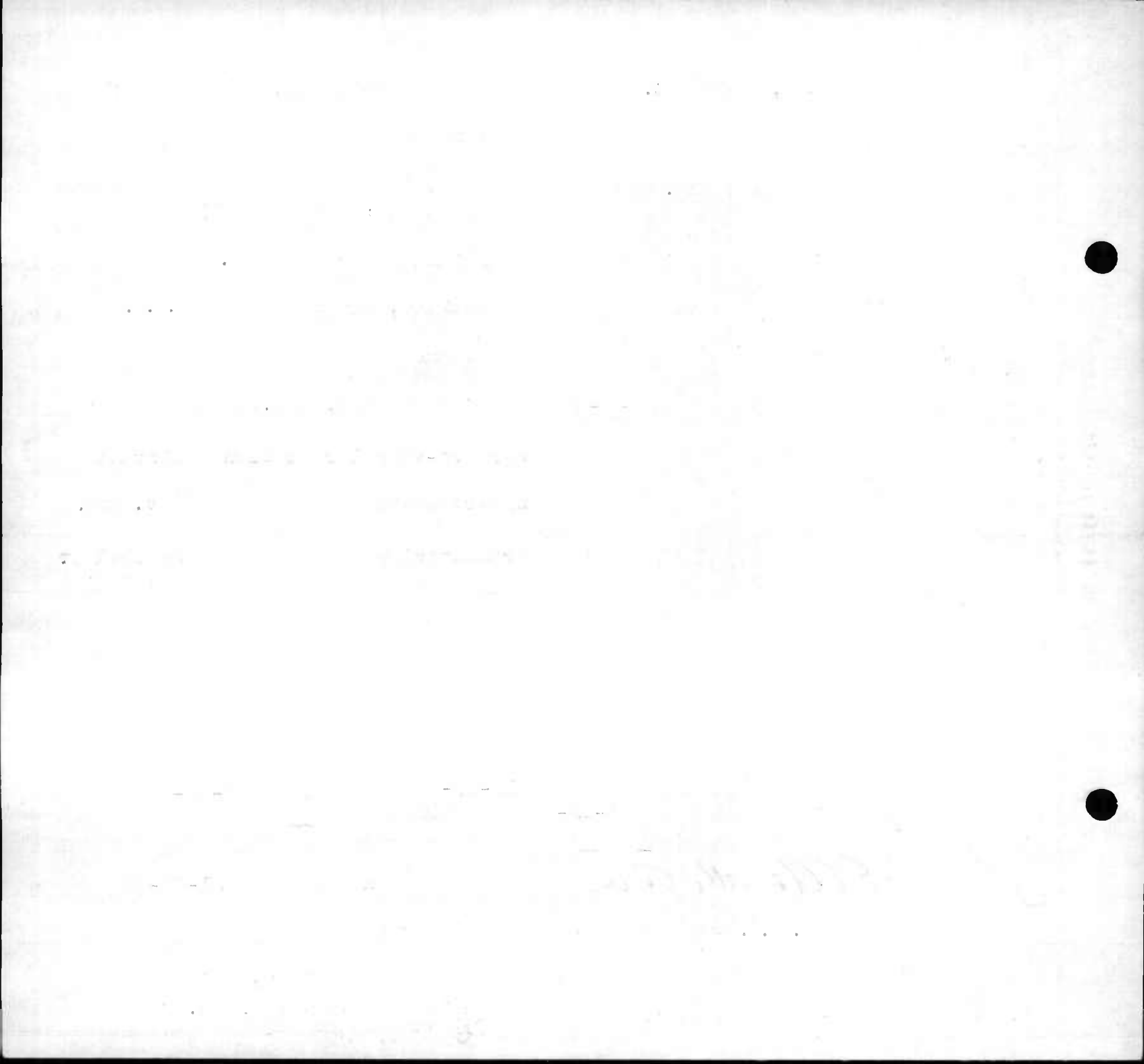
100-12-10 2 - 100-12-10

X

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

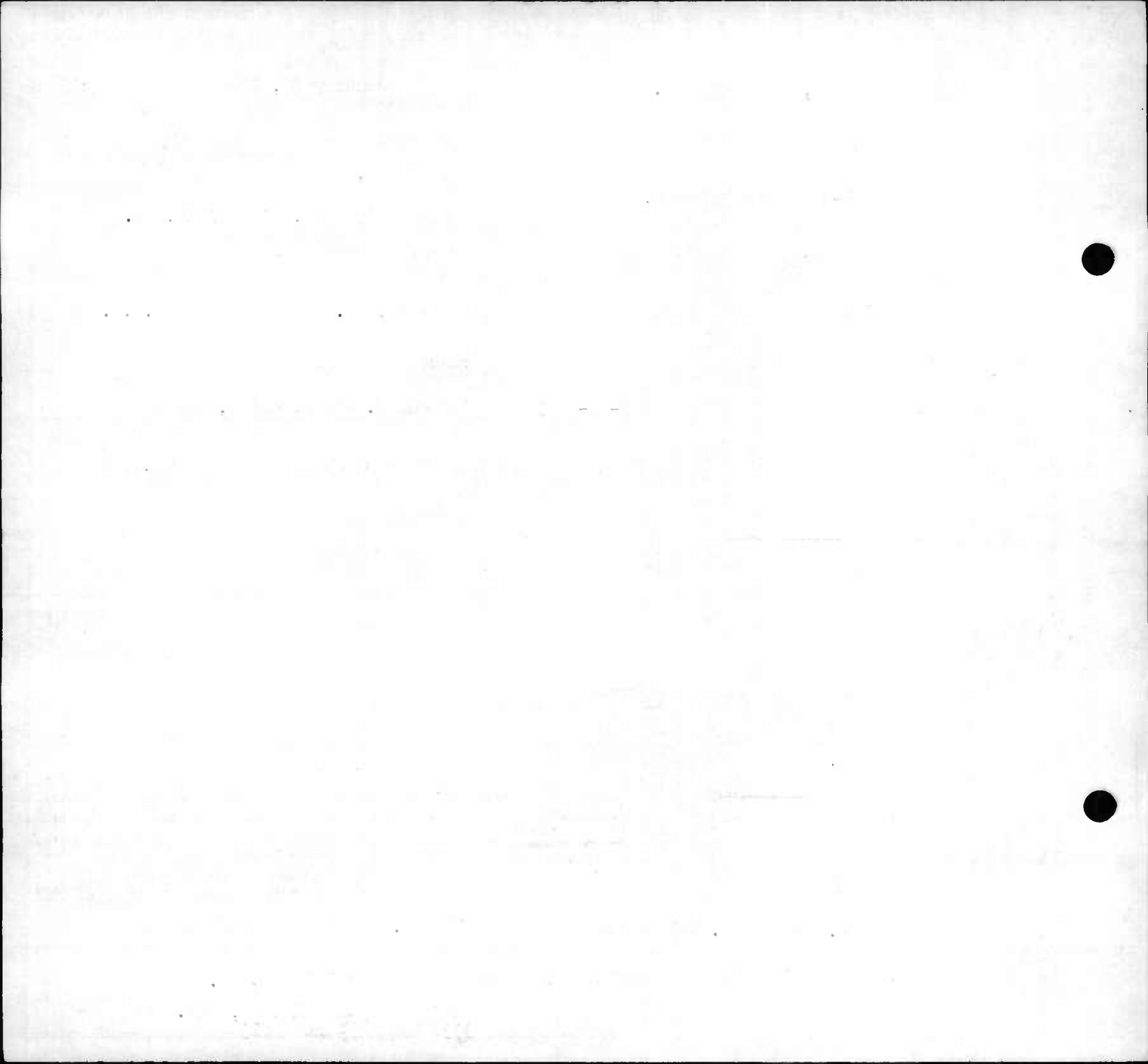
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00922	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 66 00922 CERTIFICATE OF DEATH </div>					
<div style="display: flex; justify-content: space-between;"> M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) BOEHM, LOTTIE C. </div>			<div style="display: flex; justify-content: space-between;"> 2. DATE AND HOUR OF DEATH JANUARY 27, 1966 9:30 a M. </div>		
<div style="display: flex; justify-content: space-between;"> 3. PLACE OF DEATH IN BALTIMORE, MARYLAND </div>			<div style="display: flex; justify-content: space-between;"> 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore </div>		
<div style="display: flex; justify-content: space-between;"> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Fayette Street Conv. Home </div>			<div style="display: flex; justify-content: space-between;"> C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore </div>		
<div style="display: flex; justify-content: space-between;"> D. STREET ADDRESS (If rural, give location) 2880 Kentucky Avenue 21213 </div>					
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 2/23/1877	9. AGE (In years last birthday) 88 yrs.	<div style="display: flex; justify-content: space-between;"> If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min. </div>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Keller			14. MOTHER'S MAIDEN NAME Barbara		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-54-2309	17. INFORMANT ADDRESS Elizabeth Fundt, dght., above		
<div style="display: flex; justify-content: space-between;"> 18. CAUSE OF DEATH </div>					
<div style="display: flex; justify-content: space-between;"> 18A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) cerebro-vascular accident </div>			<div style="display: flex; justify-content: space-between;"> INTERVAL BETWEEN ONSET AND DEATH minutes </div>		
<div style="display: flex; justify-content: space-between;"> 18B. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. hypertension </div>			<div style="display: flex; justify-content: space-between;"> several yrs. </div>		
<div style="display: flex; justify-content: space-between;"> 18C. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. arteriosclerosis </div>			<div style="display: flex; justify-content: space-between;"> several yrs. </div>		
<div style="display: flex; justify-content: space-between;"> 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? </div>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
<div style="display: flex; justify-content: space-between;"> 22. I certify that (I) (this hospital) attended the deceased from 12-27-1965 to 1-27-1966, that (we) lost saw the deceased alive on 1-26-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. </div>					
23A. SIGNATURE <i>E. E. Cook</i>			<div style="display: flex; justify-content: space-between;"> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> </div>		23B. DATE SIGNED 1-27-66
23C. PHYSICIAN'S NAME (Type) Dr. E.E. Cook			23D. ADDRESS M.D. 2431 Maryland Avenue		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/29/66	24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. JAN 28 1966		25B. NAME OF REGISTRAR Schimunek Funeral Home, Inc.		25C. FUNERAL DIRECTOR ADDRESS 3331 Brehms Lane #13	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

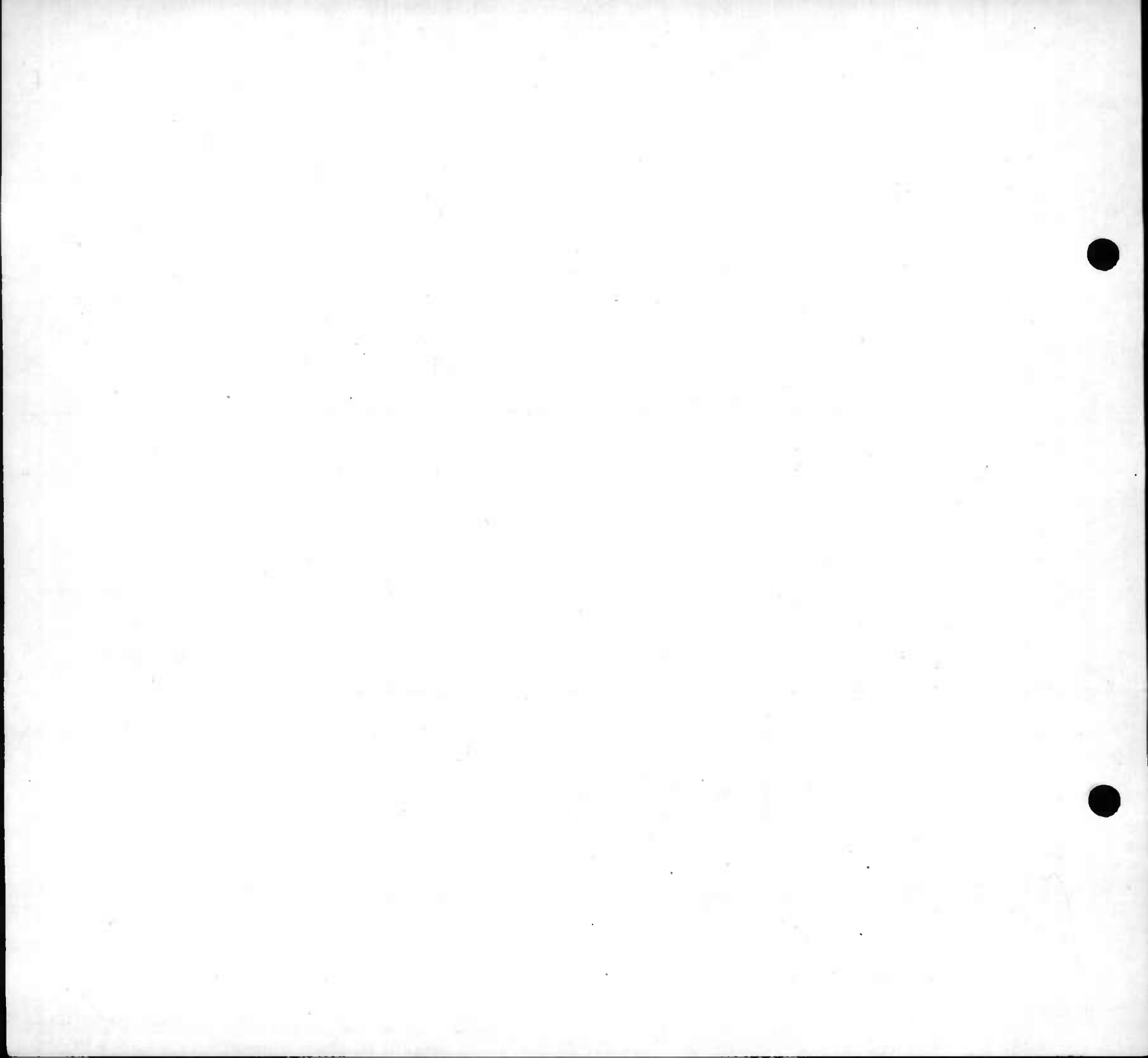
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00923	
BIRTH NO. 66 00923		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BECK, GERTRUDE M.		2. DATE AND HOUR OF DEATH January 25, 1966 4:15 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION Mel-char Nursing Home,		D. STREET ADDRESS (If rural, give location) Brandohair Road, Kingsville, Md.		E. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 12/4/74	9. AGE (In years last birthday) 91	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Ruley	
14. MOTHER'S MAIDEN NAME Frances Marshall		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-03-1983	
17. INFORMANT Mildred, H. Hines, neice, above		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) arteriosclerosis Heart Disease INTERVAL BETWEEN ONSET AND DEATH 10 years		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		21. MEDICAL CERTIFICATION 19A. DATE OF OPERATION Jan 24 1966		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NOT	
22. I certify that (I) (this hospital) attended the deceased from Jan 14 1966 to Jan 25 1966 , that (we) last saw the deceased alive on Jan 24 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.		23A. SIGNATURE Stanley Z. Felsenberg		23B. DATE SIGNED 1/26/66	
23C. PHYSICIAN'S NAME (Type) Dr. Stanley Z. Felsenberg		23D. ADDRESS 1129 E. Baltimore Street		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 1/28/66		24C. NAME of CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 28 1966		25B. NAME OF REGISTRAR Dr. Stanley Z. Felsenberg		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.	
25D. ADDRESS 3310 Broomfield Lane #13		25E. ADDRESS 3310 Broomfield Lane #13		25F. ADDRESS 3310 Broomfield Lane #13	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 66 00924		CERTIFICATE OF DEATH		Registered No. 66 00924	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) JAMES PETER REAL		2. DATE AND HOUR OF DEATH 1-27-66 4:45 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 25-43		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 30			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 36 FRANKLIN SQUARE HOSPITAL				D. STREET ADDRESS (If rural, give location) 1701 HARMON AVE					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWER	8. DATE OF BIRTH 11-9-02	9. AGE (In years last birthday) 63	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY SANITATION		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME Ida Bentley				ADDRESS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes World II War				16. SOCIAL SECURITY NO. 218-22-5692		17. INFORMANT MEDICAL RECORDS			
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION				(A) DUE TO				INTERVAL BETWEEN ONSET AND DEATH 5 days?	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIOSCLEROTIC HEART DISEASE				(B) DUE TO				2 years?	
(C)									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1-24 19 66 to 1-27 19 66, that (I) (we) last saw the deceased alive on 1-27 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Jacinto V. de Borja M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-27-66			
23C. PHYSICIAN'S NAME (Type) JACINTO V. DE BORJA M.D.				23D. ADDRESS FRANKLIN SQUARE HOSP.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/31/66		24C. NAME OF CEMETERY or CREMATORY Western Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 28 1966		25B. NAME OF REGISTRAR J. J. Hollins		25C. FUNERAL DIRECTOR J. J. Hollins		ADDRESS 23, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00925		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 00925	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) ALICE STRINGFIELD			2. DATE AND HOUR OF DEATH 1 26 66 2:50 P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27 D. STREET ADDRESS (If rural, give location) 4321 RIDGE AVENUE		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 1 8 99	9. AGE (In years lost birthday) 66	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA	
13. FATHER'S NAME ROY			14. MOTHER'S MAIDEN NAME MARY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT AND CATON AVENUE ST. AGNES HOSPITAL RECORDS WILKENS	
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(A) DUE TO Myocardial Infarction (B) DUE TO Coronary Artery Disease (C) DUE TO Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from DECEMBER 30 19 65 to JANUARY 26 19 66 , that (X) (we) last saw the deceased alive on JANUARY 26 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (didn't) view the body after death.					
23A. SIGNATURE M. Rodriguez M.D.			23B. DATE SIGNED 1-27-66		
23C. PHYSICIAN'S NAME (Type) M. RODRIGUEZ, M.D.			23D. ADDRESS ST. AGNES HOSPITAL; CATON & WILKENS AVE		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/28/66		24C. NAME of CEMETERY or CREMATORY Meadowridge Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 28 1966		25B. NAME OF REGISTRAR John J. Kelly	
25C. FUNERAL DIRECTOR Funeral Home 1328 Salphur Sp Rd.		25D. ADDRESS			

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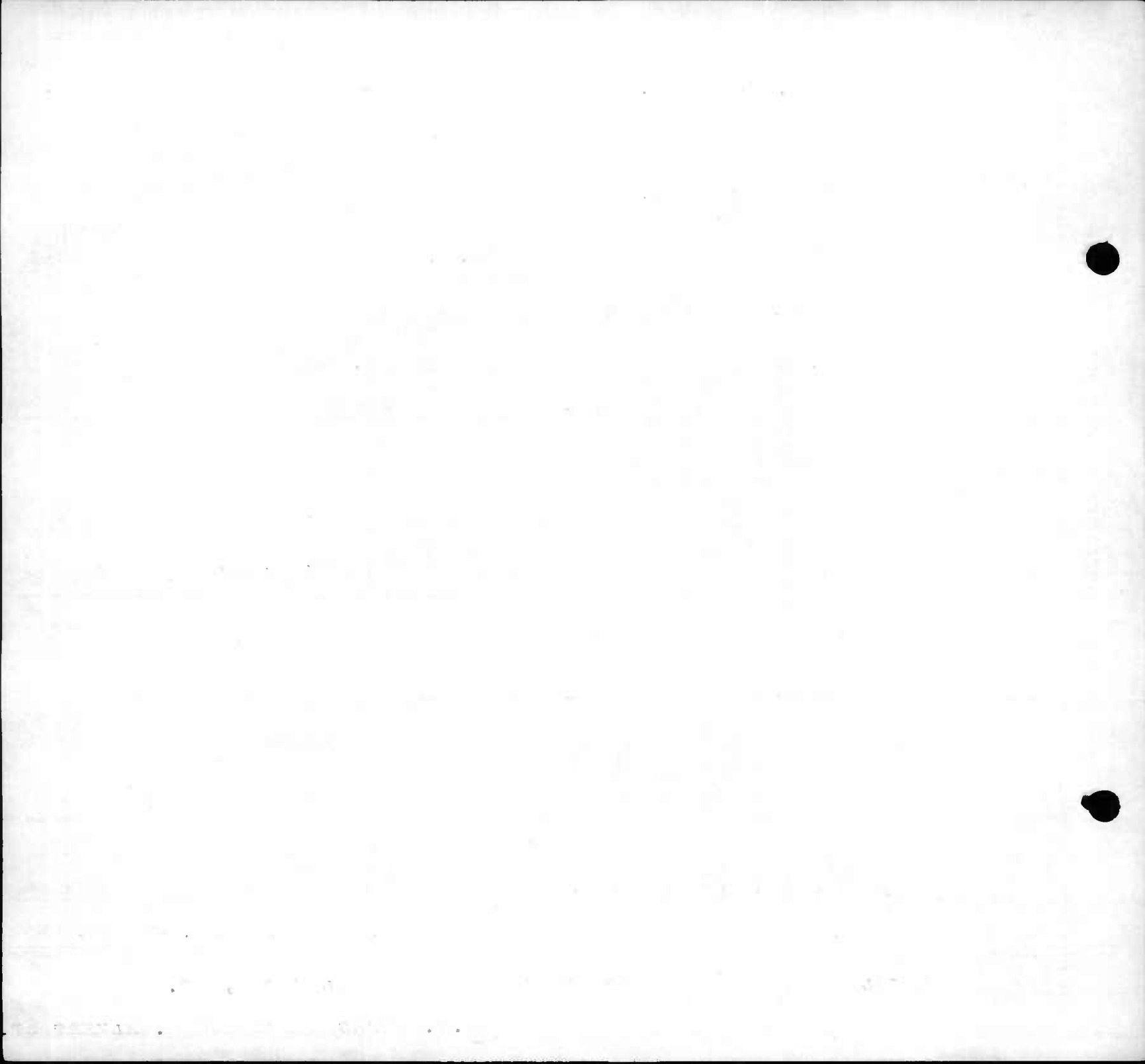
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

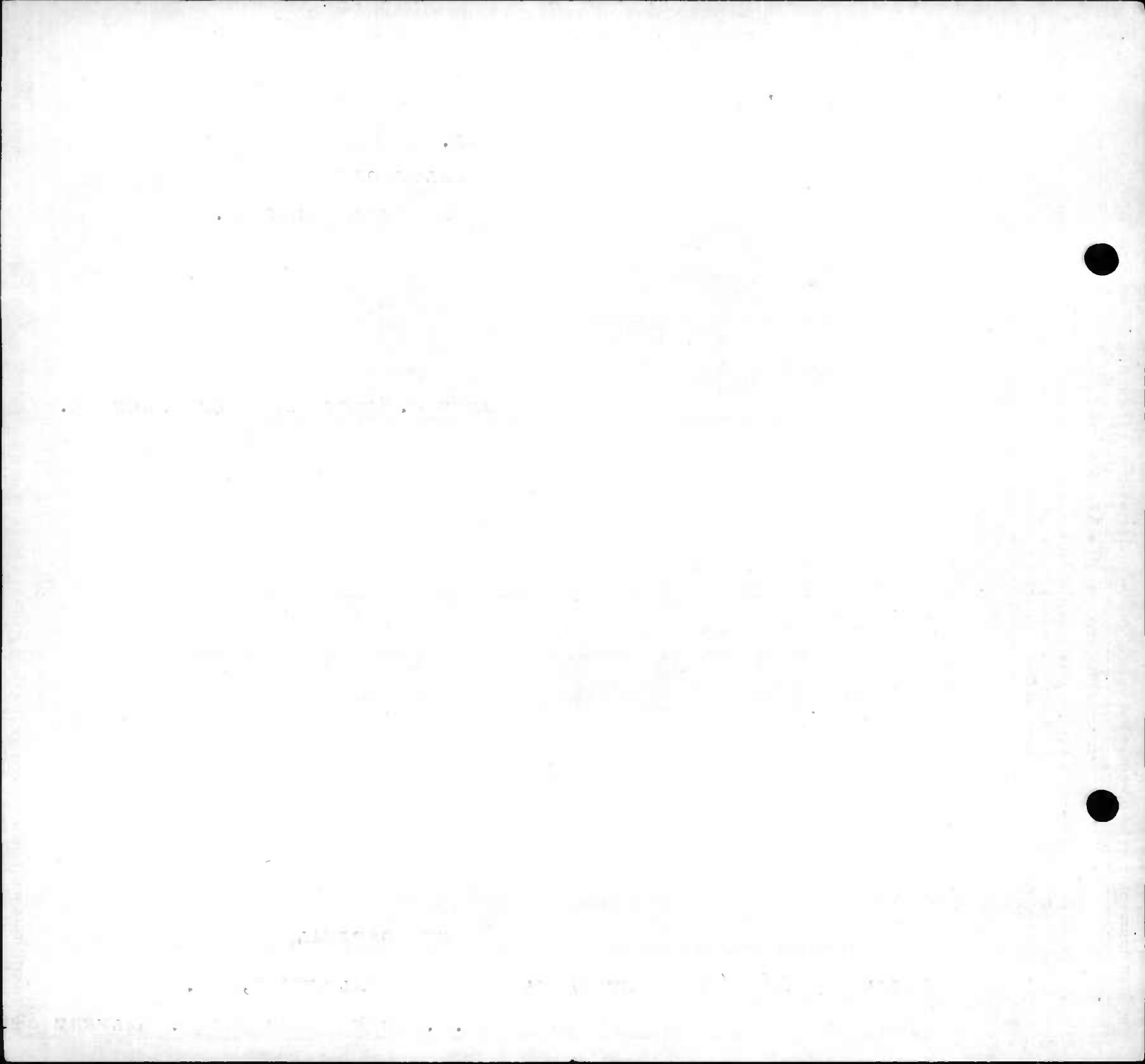
BALTIMORE CITY HEALTH DEPARTMENT									
66 00926					CERTIFICATE OF DEATH		Registered No. 66 00926		
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
ROSS, Miss Jane H.					1-26-66 7:20 A. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JENKINS MEMORIAL HOSPITAL 1000 S Caton Ave. Baltimore, Md. 21229					A. STATE Street Homewood Apts- 31st & Charles				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21218				
D. STREET ADDRESS (If rural, give location) STATE MARYLAND					12-02				
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Mar. 13, 1875	9. AGE (In years last birthday) 90	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Social worker			10B. KIND OF BUSINESS OR INDUSTRY Psychiatry- Medical		11. BIRTHPLACE (State or foreign county) Baltimore Md			12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James B. Ross					14. MOTHER'S MAIDEN NAME Margaret A. Coghlan				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 220-44-9291		17. INFORMANT MEDICAL RECORDS ROOM			ADDRESS	
18. 334X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <u>cachexia</u> DUE TO (B) <u>chronic brain syndrome</u> DUE TO (C) <u>cerebral arteriosclerosis</u> years			INTERVAL BETWEEN ONSET AND DEATH <u>weeks</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Arteriosclerotic Heart Disease</u>					<u>6 months</u>				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (H) (this hospital) attended the deceased from <u>8/7 1963</u> to <u>1/26 1966</u> , that (H) (we) last saw the deceased alive on <u>1/26 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>J. Raymond Gladue</u> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <u>1/26/66</u>	
23C. PHYSICIAN'S NAME (Type) J. RAYMOND GLADUE					23D. ADDRESS M.D. JENKINS MEMORIAL HOSP. 1000 S. Caton Ave. 21229				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/29/66		24C. NAME OF CEMETERY or CREMATORY CATHEDRAL		24D. LOCATION (City, town, or county) (State) BALTIMORE, Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 28 1966			25B. NAME OF REGISTRAR <u>J. H. MEARS</u>			25C. FUNERAL DIRECTOR H. H. MEARS & SON 805 N. CALVERT ST.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
66 00927		66 00927		66 00927	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Rita T. Magee</u>			
2. DATE AND HOUR OF DEATH <u>1-24-66</u> <u>10:00</u> P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>12-07</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>37 Mercy Hospital</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
		D. STREET ADDRESS (If rural, give location) <u>319 WYMAN PARK DR.</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>1-17-87</u>	9. AGE (In years last birthday) <u>78</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>Charles Thumel</u>		14. MOTHER'S MAIDEN NAME <u>Anna Bauman</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>JAMES J. MAGEE 319 WYMAN PARK DR.</u>	
18. <u>420.14-13-37.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute Myocardial Infarction</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>Acute</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>CARCINOMA OF GALL BLADDER</u>		?	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nailify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1-22</u> 19 <u>66</u> to <u>1-24</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1-24</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>David Nagel</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1-25-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>J. DAVID NAGEL</u>		23D. ADDRESS M.D. <u>MERCY HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1/28/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>CATHEDRAL</u>	
24D. LOCATION <u>BALTIMORE, MD.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1966</u>		25B. NAME OF REGISTRAR <u>HOW. MEARS</u>		25C. FUNERAL DIRECTOR ADDRESS <u>805 N. CALVERT ST.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. <u>66 00928</u>	
BIRTH NO. <u>66 00928</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>WALTER FORNE Y</u>	
2. DATE AND HOUR OF DEATH <u>1-25-66</u> <u>3:00 P.</u> M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>255 STRICKER ST.</u>		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>FRANKLIN SQUARE HOSP.</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>NOT MARRIED</u>	8. DATE OF BIRTH <u>4-15-95</u>	9. AGE (In years last birthday) <u>70</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>FRANK B. FORNEY</u>	
14. MOTHER'S MAIDEN NAME <u>MARY ANN KEARNS</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unknown NO</u>		16. SOCIAL SECURITY NO. <u>212-14-0867</u>	
17. INFORMANT <u>MARIE TOLSON</u>		ADDRESS <u>6295 RAMSAY BLVD</u>		18. <u>540.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>PULMONARY EMBOLISM</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>POST-OP COMPLICATION</u> <u>BLEEDING PEPTIC ULCER</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>11-21-66</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>BLEEDING PEPTIC ULCER</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan. 15</u> 19 <u>66</u> to <u>Jan. 25</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Jan. 21</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ramirez</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>1-25-66</u>	
23C. PHYSICIAN'S NAME (Type) <u>R. Suarez</u>				23D. ADDRESS <u>Franklin Square Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/29/66</u>		24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	
24D. LOCATION (City, town, or county) <u>Baltimore</u>		(State) <u>MD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1966</u>	
25B. NAME OF REGISTRAR <u>John J. Gowanston Inc.</u>		25C. FUNERAL DIRECTOR <u>John J. Gowanston Inc.</u>		ADDRESS <u>23rd St.</u>	

MILWAUKEE, WISCONSIN

FRANKLIN SQUARE HOTEL BALTIMORE

225 STREET ST

MALE WHITE NOT MARRIED 4-17-25 75

LABORER BALTIMORE, MARYLAND U.S.A.

FRANK B. FORNEY AND AN KERN

MARIE TOLSON, 225 STREET ST, BALTIMORE, MARYLAND

1-31-26 RECEIVED POLICE DEPT

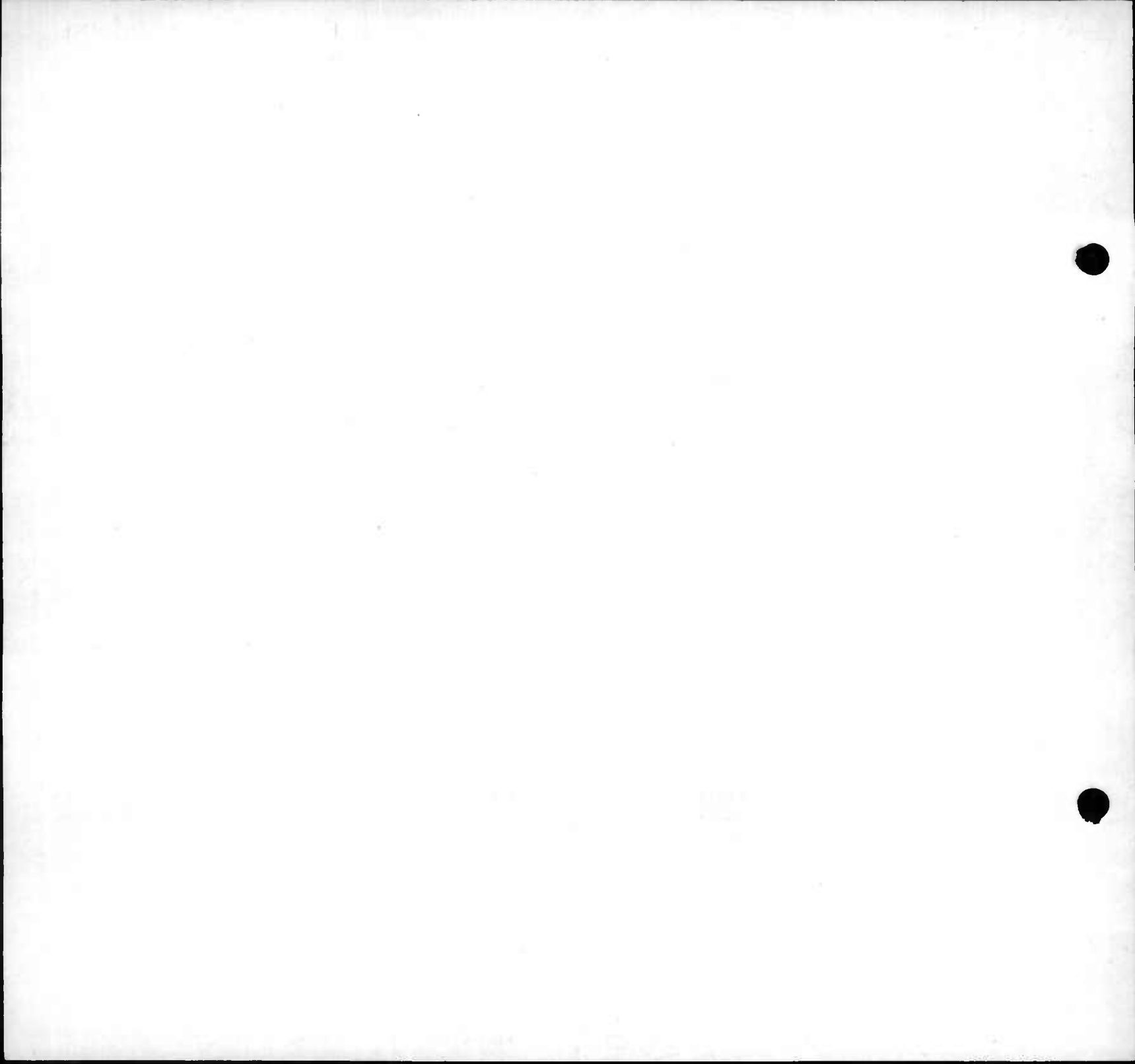
for 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

1-22-26
Franklin Square Hotel

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

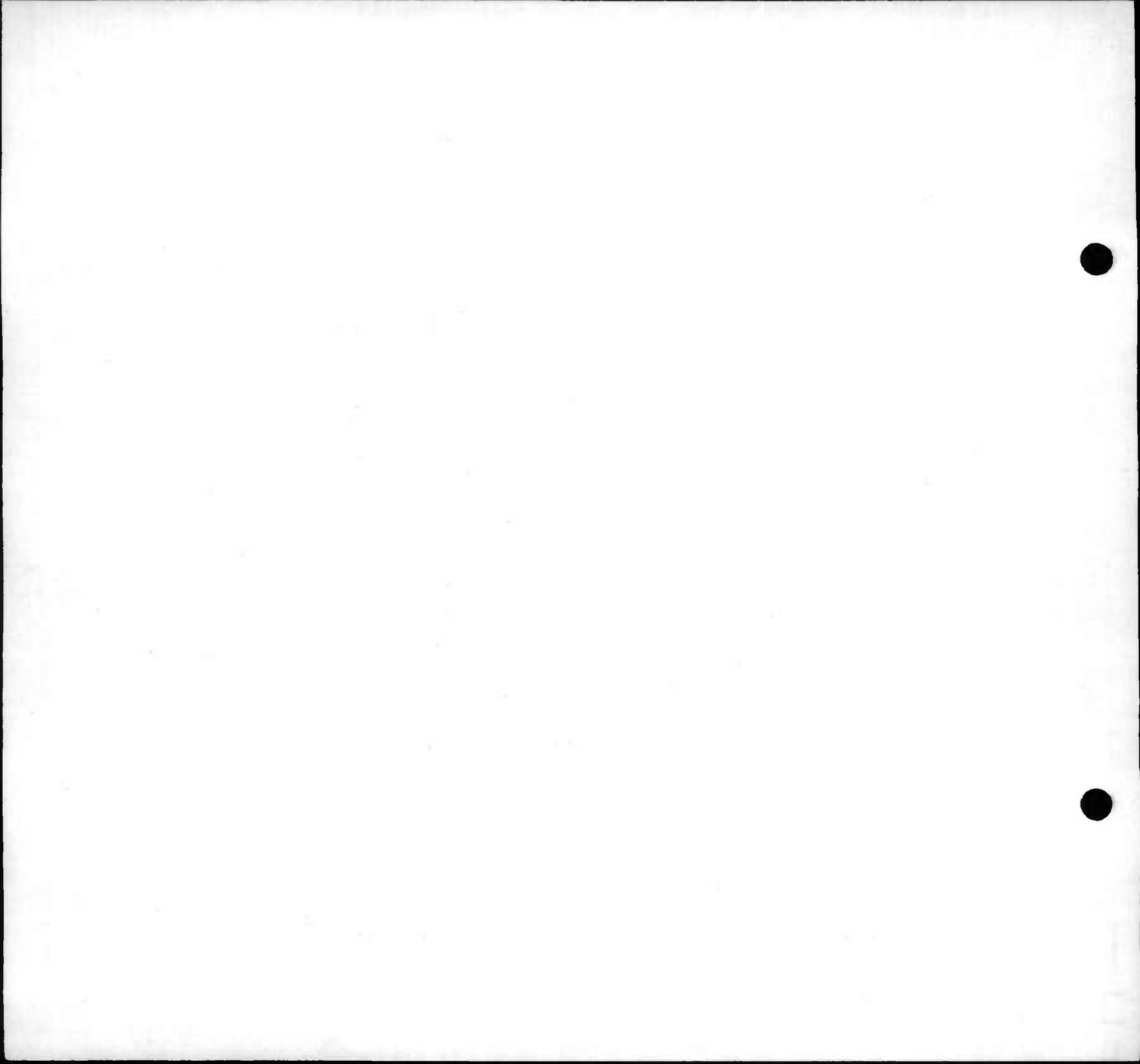
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 00929</u>	
BIRTH NO. <u>66 00929</u>		CERTIFICATE OF DEATH			
M.E. CASE NO. <u>66 00929</u>		1. NAME OF DECEASED (Type or Print) <u>Perry, James</u>			
2. DATE AND HOUR OF DEATH <u>21 Jan 66</u> <u>545</u> A.M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
D. STREET ADDRESS (If rural, give location) <u>242 Zeppelin Ave.</u>		5. SEX <u>M</u> 6. RACE <u>N</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>?</u>			
8. DATE OF BIRTH <u>?</u> 9. AGE (In years last birthday) <u>70</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>?</u>	
10B. KIND OF BUSINESS OR INDUSTRY <u>?</u>		11. BIRTHPLACE (State or foreign country) <u>?</u>		12. CITIZEN OF WHAT COUNTRY? <u>?</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>?</u>	
16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT ADDRESS			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <u>Cerebral vascular accident</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cerebral intracerebral</u> INTERVAL BETWEEN ONSET AND DEATH <u>15 Dec. 65</u>				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
19A. DATE OF OPERATION <u>?</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>18 Dec. 1965</u> to <u>21 Jan. 1966</u> , that (I) (we) last saw the deceased alive on <u>21 Jan. 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Richard P. Norgaard</u> M.D.				23B. DATE SIGNED <u>21 Jan 66</u>	
23C. PHYSICIAN'S NAME (Type) <u>RICHARD P. NORGAARD</u> M.D.				23D. ADDRESS <u>University Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>JAN 25 1966</u>		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY <u>ANATOMY BOARD OF MARYLAND</u>	
24D. LOCATION <u>UNIVERSITY MEDICAL SCHOOL</u>		24E. NAME OF REGISTRAR <u>242 Zeppelin Ave.</u>		24F. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1966</u>		25B. NAME OF REGISTRAR <u>242 Zeppelin Ave.</u>		25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		66 00930		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00930	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Algot Nahrstrom</i>		2. DATE AND HOUR OF DEATH <i>21 Jan 66</i> <i>10³⁰</i> <i>A</i> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		D. STREET ADDRESS (If rural, give location) <i>102 N. Paca ST.</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>University of Maryland Hospital</i>		5. SEX <i>M</i>		6. RACE <i>W</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>S</i>	
8. DATE OF BIRTH <i>21 Nov 87</i>		9. AGE (In years last birthday) <i>78</i>		10. If Under 1 Yr. Months Days		11. If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Seaman</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Sweden</i>		12. CITIZEN OF WHAT COUNTRY? <i>Sweden</i>	
13. FATHER'S NAME <i>Votel Nahrstrom</i>		14. MOTHER'S MAIDEN NAME <i>Olivia</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Unkn.</i>		16. SOCIAL SECURITY NO. <i>215-22-3549 A</i>	
17. INFORMANT <i>Midtown Nursing Home.</i>		ADDRESS		18. CAUSE OF DEATH <i>Myocardial infarction</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		21. (A) <i>Myocardial infarction</i> DUE TO		3 days	
22. (B) <i>Congestive Heart failure</i> DUE TO		4 days		23. (C) <i>Arteriosclerotic cardiovascular disease</i> DUE TO		4 + months	
24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Probable Carcinoma of Pancreas</i>		25. ?		26. ?		27. ?	
28. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <i>18 Jan 66</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Respiratory distress</i>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner) <i>N/A</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>N/A</i>		21C. WHERE DID INJURY OCCUR? <i>N/A</i>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>N/A</i>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <i>N/A</i>		21F. HOW DID INJURY OCCUR? <i>N/A</i>		22. I certify that (I) (this hospital) attended the deceased from <i>12 Jan</i> 19 <i>66</i> to <i>21 Jan</i> 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>21 Jan</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		23A. SIGNATURE <i>Robert S. Holt</i>	
23B. PHYSICIAN'S NAME (Type) <i>Robert S. Holt</i>		23C. ADDRESS <i>University Hospital, Baltimore, Md.</i>		23D. DATE SIGNED <i>21 Jan 66</i>		23E. M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>JAN 25 1966</i>		24B. DATE <i>JAN 25 1966</i>		24C. NAME OF CEMETERY OR CREMATORY <i>ANATOMY BOARD OF MARYLAND</i>		24D. LOCATION (City) (Town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 28 1966</i>		25B. NAME OF REGISTRAR <i>CELESTINE</i>		25C. FUNERAL DIRECTOR <i>MORTUARY SERVICE - BCHD</i>		25D. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		66 00931		66 030800-24	
BIRTH NO.		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Epkins, Esther.		2. DATE AND HOUR OF DEATH 1/16/66 10:05 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND University Hospital FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY AD. C. CITY OR TOWN (If outside city limits, write RURAL and give township) 32-00 D. STREET ADDRESS (If rural, give location) Crownsville State Hospital.			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) unknown	8. DATE OF BIRTH 10/3/12	9. AGE (In years last birthday) 52	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown.		10B. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Florida.	
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unknown		17. INFORMANT ADDRESS	
18. 13-0 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) medialinitis, septemia. DUE TO (B) Esophageal for CA-Esophagus. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		fistula between trachea & Mediastinum.			
19A. DATE OF OPERATION 3 12/27/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA-Esophagus.		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) none		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) none.	
21D. TIME OF INJURY (APPROX.) none		21E. INJURY OCCURRED While At Work <input type="checkbox"/> none While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? none	
22. I certify that (I) (this hospital) attended the deceased from 12/16 1965 to 12/16 1966 , that (I) (we) last saw the deceased alive on 12/16 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Fred R. Eilber		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/16/66.	
23C. PHYSICIAN'S NAME (Type) FRED R. EILBER.		23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) JAN 25 1966		24B. DATE JAN 25 1966		24C. NAME OF CEMETERY or CREMATORY ANATOMY BOARD OF MARYLAND	
24D. LOCATION (City, town, or county) (State) UNIVERSITY MEDICAL SCHOOL		25A. DATE REC'D BY HEALTH DEPT. JAN 28 1966			
25B. NAME OF REGISTRAR 2-29-66		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD			

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Investigation

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FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00932	
BIRTH NO. 66-00999 66 00932		M.E. CASE NO.		4	
1. NAME OF DECEASED (Type or Print) <u>COOK, BOBBY BOY</u>		2. DATE AND HOUR OF DEATH <u>1/16/66</u> <u>9:15 P.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY HOSPITAL</u>		A. STATE <u>MD.</u> B. COUNTY <u>15-13</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
		D. STREET ADDRESS (If rural, give location) <u>4424 Reisterstown Rd.</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>1/16/66</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>RONALD COOK</u>			14. MOTHER'S MAIDEN NAME <u>M. CEGURNA McCLAIN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>FATHER 4424 REISTERSTOWN RD</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>7613-1</u> <u>RESPIRATORY DISTRESS</u> <u>SYNDROME</u>		CAUSE OF DEATH (A) <u>RESPIRATORY DISTRESS</u> DUE TO <u>SYNDROME</u> (B) <u>PREMATURITY</u> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr 15 min</u> <u>BIRTH</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<u>PREMATURE RUPTURED MEMBRANES - 44 WKS</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>✓</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1/16</u> 19 <u>66</u> to <u>1/16</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/16</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ruth Luddy</u>				23B. DATE SIGNED <u>1/16/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>RUTH LUDDY</u>				23D. ADDRESS <u>University Medical School</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>JAN 25 1966</u>		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY <u>ANATOMY BOARD OF MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1966</u>		25B. NAME OF REGISTRAR <u>0 2 0</u>		25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u>	

111 111
111 111

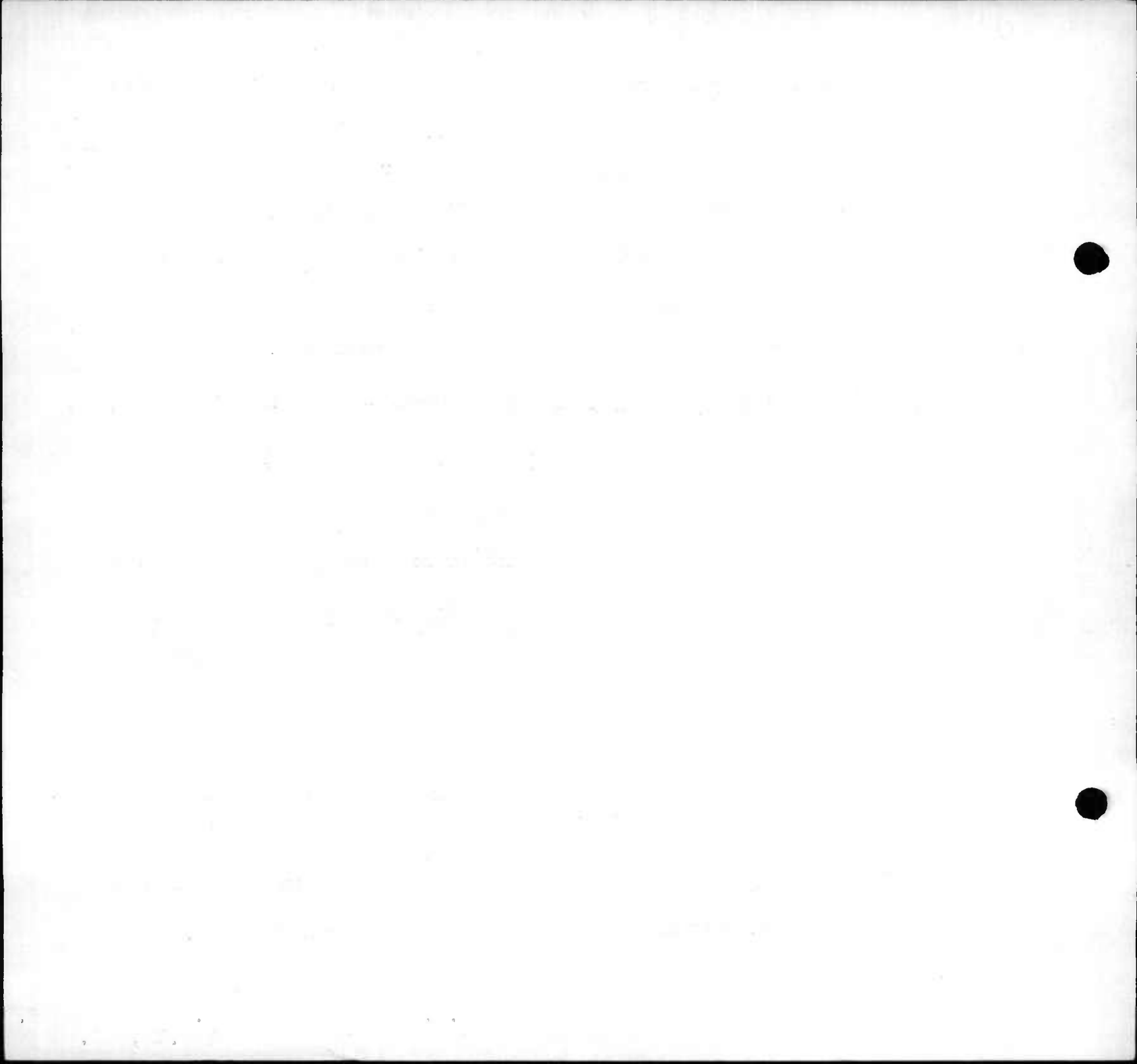
111 111

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

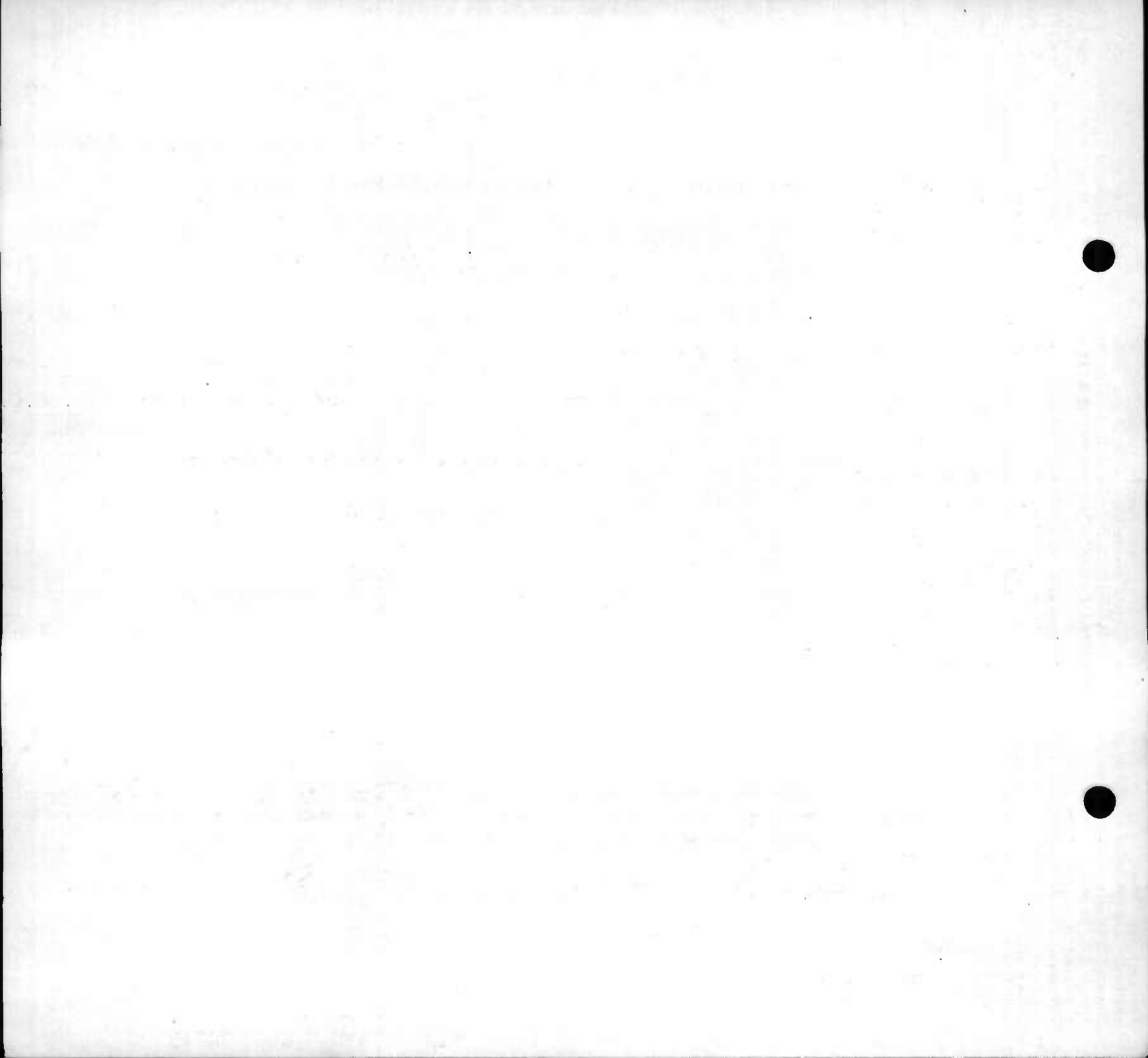
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
66 00933		CERTIFICATE OF DEATH		66 00933	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Leroy Bryan Cross		Jan. 26, 1966 4: 15 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Pk. Drive & 31st Street		A. STATE Md.			
		B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 2900 Greenmount Ave.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 11/27/80	9. AGE (In years last birthday) 85	10. If Under 1 Yr. Months; Days If Under 24 Hrs. Hours; Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY USN		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Charles Cross		14. MOTHER'S MAIDEN NAME Elizabeth Bryan			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes USN 1925		16. SOCIAL SECURITY NO. 214-20-7254		17. INFORMANT Records- US PHS Hospital, Balto, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cardiac arrest, clinical DUE TO Coronary atherosclerosis , DUE TO marked Diabetes mellitus DUE TO		INTERVAL BETWEEN ONSET AND DEATH Hours Years Years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Bronchopneumonia Emphysema & bronchiectasis		Days Years	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan. 15 19 66 to Jan. 26 19 66, that (I) (we) last saw the deceased alive on Jan. 26 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas J. Lau, Surgeon (R)				23B. DATE SIGNED 1/27/66	
23C. PHYSICIAN'S NAME (Type) Thomas J. Lau, Surgeon (R)		23D. ADDRESS US PHS Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/29/66		24C. NAME OF CEMETERY or CREMATORY Loudon Park	
24D. LOCATION Baltimore,		24E. LOCATION (City, town, or county) (State) Maryland			
25A. DATE REC'D BY HEALTH DEPT. JAN 28 1966		25B. NAME OF REGISTRAR H.W. Jenkins		25C. FUNERAL DIRECTOR & Sons Co. 4905 York Rd. Balto. 12, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 66 00934					CERTIFICATE OF DEATH					Registered No. 66 00934									
M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) NORMAN (Norman) WELCH					2. DATE AND HOUR OF DEATH 1/25/66 8:15 A.M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived if institution: residence before admission) A. STATE MARYLAND B. COUNTY 11-02					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL					D. STREET ADDRESS (If rural, give location) 5 W. PRESTON ST														
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never married		8. DATE OF BIRTH 9/3/13		9. AGE (In years last birthday) 52		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NIGHTWATCHMAN					10B. KIND OF BUSINESS OR INDUSTRY LYRIC THEATER					11. BIRTHPLACE (State or foreign country) MARYLAND					12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME DALLAS WELCH					14. MOTHER'S MAIDEN NAME MATILDA HORST														
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO. 218 18 4227					17. INFORMANT 623 Alabama Ave. South East PATIENT Mrs Wortley Welch Wash. D.C.					ADDRESS				
18. 5-9-3X I					CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)					(A) UREMIA + UREMIC PERICARDITIS DUE TO					5 MONTHS									
ANTECEDENT CAUSES					(B) CHRONIC RENAL FAILURE DUE TO					?									
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C)														
II																			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE																			
19A. DATE OF OPERATION 0					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) NO					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from 1/10 19 60 to 1/25 19 66, that (I) (we) last saw the deceased alive on 1/25 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE Donald Goldney M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED 1/25/66									
23C. PHYSICIAN'S NAME (Type) Donald Goldney M.D.					23D. ADDRESS Maryland General Hospital														
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 1/28/66					24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery					24D. LOCATION (City, town, or county) Baltimore Maryland (State)				
25A. DATE REC'D BY HEALTH DEPT. JAN 28 1966					25B. NAME OF REGISTRAR					25C. FUNERAL DIRECTOR HENRY SANDER & SONS INC. BALTIMORE MARYLAND 21213					ADDRESS				



FUNERAL DIRECTOR: IMPORTANT

Written approval must be obtained before the remains are embalmed or final disposition is made.

HENRY SANDER & SONS INC.
BALTIMORE MARYLAND 21213

007/11 133-1 2000000 50 Dec 1971

1st Bank

Proposed
Building
415 5th Street

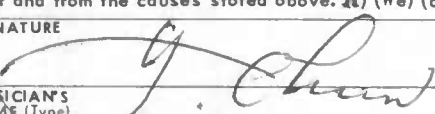
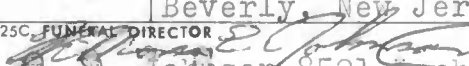
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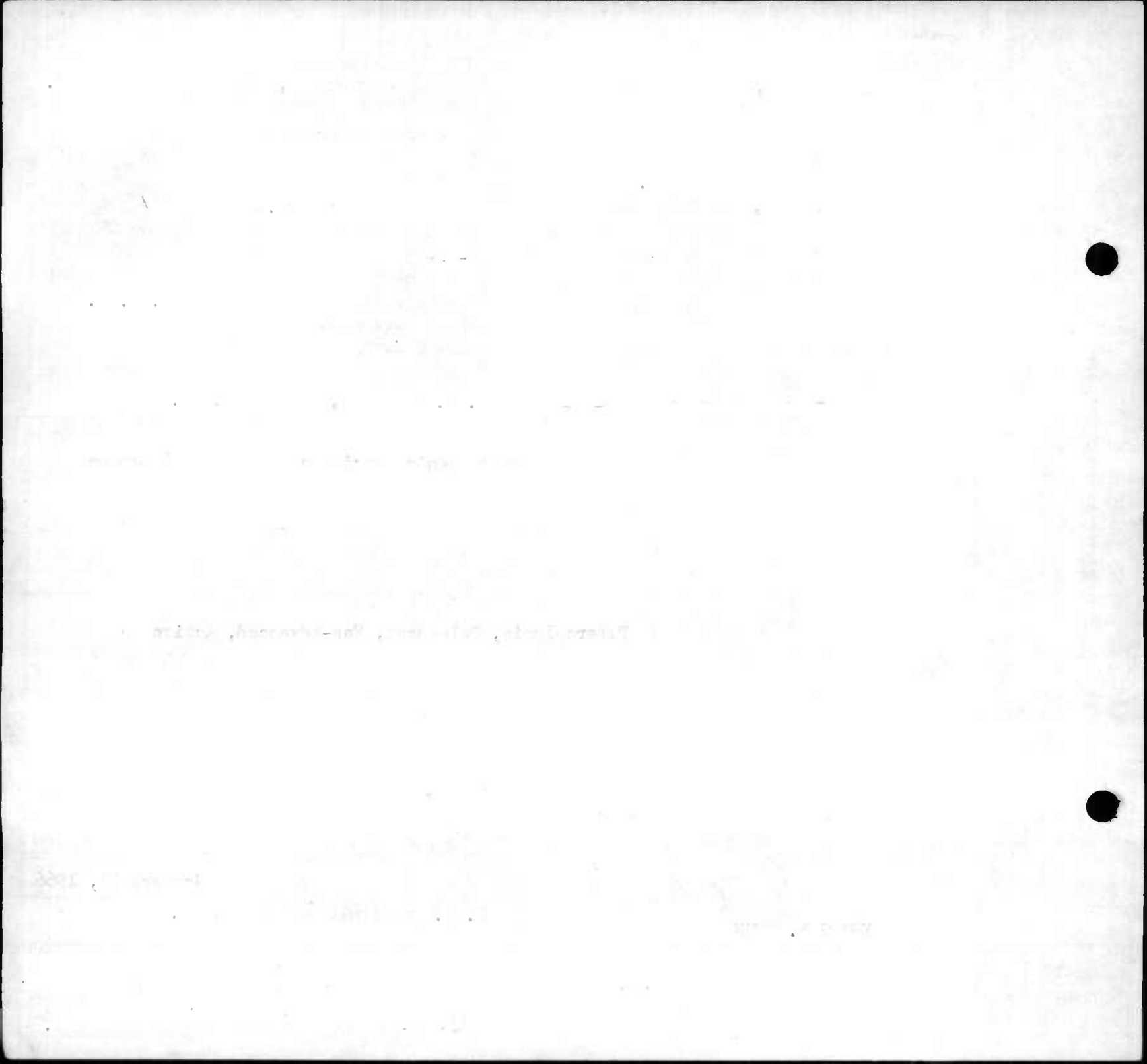
10 20 30

RECEIVED JAN 1972

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00936		CERTIFICATE OF DEATH		Registered No. 66 00936	
1. NAME OF DECEASED (Type or Print) BERNHEIMER, Charles Marshall			2. DATE AND HOUR OF DEATH January 27, 1966 1:15 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218			A. STATE New Jersey Gloucester B. COUNTY 1/27		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Williamstown		
			D. STREET ADDRESS (If rural, give location) Box 538 Wildwood Ave., RD # 3		
5. SEX Male	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8-26-85	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Henry Bernheimer			14. MOTHER'S MAIDEN NAME Martha Young		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 7-24-18 to 1-30-21		16. SOCIAL SECURITY NO. 198-09-1718	17. INFORMANT Records V. A. Hospital, Baltimore, Md. 21218 ADDRESS		
18. 162-14002-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Bronchogenic Carcinoma ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Bronchogenic Carcinoma DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 8 months		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Tuberculosis, Pulmonary, Far-Advanced, Active					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (A) (this hospital) attended the deceased from June 3, 1965 to January 27, 1966 , that (A) (we) last saw the deceased alive on January 27, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (A) (We) (did) (XXXX) view the body after death.					
23A. SIGNATURE  YOUNG E. CHUN			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED January 28, 1966
23C. PHYSICIAN'S NAME (Type) YOUNG E. CHUN			23D. ADDRESS V. A. Hospital, Baltimore, Md. 21218		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 2/1/66	24C. NAME OF CEMETERY or CREMATORY U.S. National	24D. LOCATION (City, town, or county) (State) Beverly, New Jersey		
25A. DATE REC'D BY HEALTH DEPT. JAN 28 1966		25B. NAME OF REGISTRAR W. E. Johnson	25C. FUNERAL DIRECTOR  W. E. Johnson 8521 Loch Raven Bl.		



1

66 00937

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 00937

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LILLIE L. POPE

2. DATE AND HOUR PRONOUNCED DEAD

January 27, 1966

6:10 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

129 S. Willard St.

5. SEX

female

6. RACE

negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

MAY 12, 1931

9. AGE (In years
last birthday)

34

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Nurses Aide

10B. KIND OF BUSINESS OR INDUSTRY

Hospital

11. BIRTHPLACE (State or foreign country)

Stoney Creek, VA

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Milton

14. MOTHER'S MAIDEN NAME

MARY

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Henry Pope 2515 W. Lombard St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Malnutrition and dehydration
DUE TO cancer of the cervix

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breiteneker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-27-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1-31-66

23C. NAME OF CEMETERY or CREMATORY

MT. Auburn

23D. LOCATION

(City, town, or county)

BA No.

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JAN 28 1966

MORTON + DOTT

1701 Laurens St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00938		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00938	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARY COOPER			
2. DATE AND HOUR OF DEATH JAN 25-1966		M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2115 PARK AVE		A. STATE Md. 13-01			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 2115 PARK AVE			
5. SEX Fe	6. RACE N.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 3-30-1885	9. AGE (In years last birthday) 80	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Ruth Bailey 2115 Park Ave	
18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Arterio sclerosis ? (B) old Rt Hemiplegia ? (C) Cardio Vascular Disease ?		INTERVAL BETWEEN ONSET AND DEATH ?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work [] Not While At Work []		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb 1966 to Jan 25 1966, that (I) (we) last saw the deceased alive on Jan 20 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. R. Johnson M.D.		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) H. R. Johnson M.D.		23D. ADDRESS 403 Medarts Bg			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-28-66		24C. NAME OF CEMETERY OR CREMATORY MT. Auburn	
24D. LOCATION (City, town, or county) (State) Balto. Md.					
25A. DATE REC'D BY HEALTH DEPT. JAN 28 1966		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR MORTON + DYETT	
				ADDRESS 1701 LAURENS	



1

66 00939

BALTIMORE CITY HEALTH DEPARTMENT

66 00939

BIRTH NO. 65-19172 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

M.E. CASE NO. _____

1. NAME OF DECEASED (Type or Print) Joseph Smith, Jr			2. DATE AND HOUR PRONOUNCED DEAD 1/22/66 11:15 a. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY _____ C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1416 Mt. Royal Ave.		
5. SEX male	6. RACE colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Child	8. DATE OF BIRTH 8/5/65	9. AGE (In years last birthday) 5	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Joseph Smith			14. MOTHER'S MAIDEN NAME Joyce Ann		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr Joseph Smith, Sr	
				ADDRESS 1005 McKean Ave	

MEDICAL CERTIFICATION	18. CAUSE OF DEATH 453 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Sepsis (A) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Gangrene, left leg (B) DUE TO (C) _____				INTERVAL BETWEEN ONSET AND DEATH	
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
	19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
	21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
	21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
	22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
	ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/23/66	
	EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
			ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
	23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 1/28/66		23C. NAME of CEMETERY or CREMATORY Mt Auburn Cemetery	
23D. LOCATION (City, town, or county) (State) Baltimore Md		24A. DATE REC'D BY HEALTH DEPT. JAN 28 1966		24B. NAME OF REGISTRAR Robert E. Spitz		
		24C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W North Ave		

VALLEY FORDS

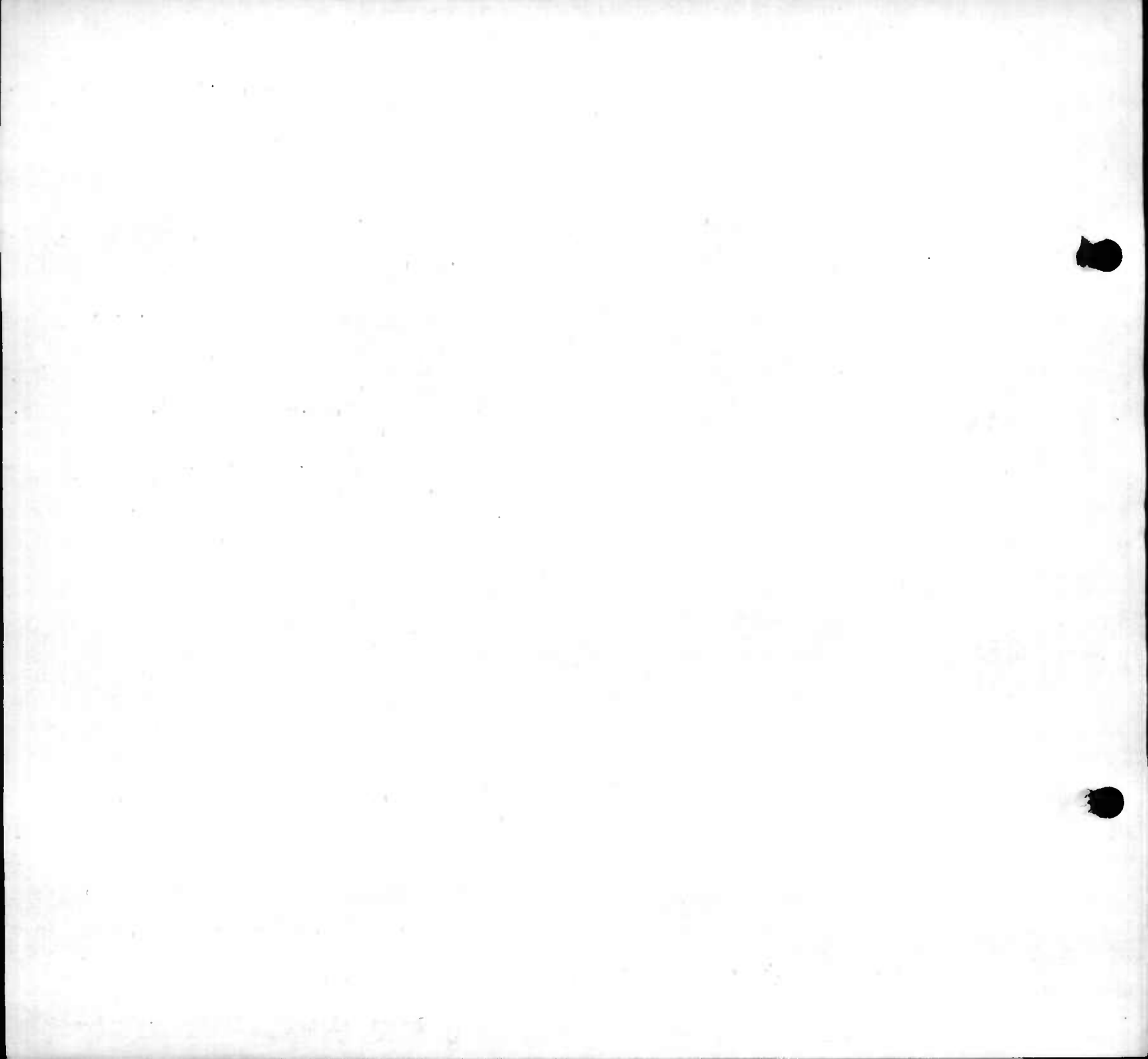
1

2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 00910</u>	
BIRTH NO. <u>66 00910</u>				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>William Brown</u>				January 21, 1966 1:05p M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland 21217</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>Maryland</u> B. COUNTY <u>1602</u>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
				D. STREET ADDRESS (If rural, give location) <u>1021 N. Calhoun Street</u>	
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>unknown</u>	8. DATE OF BIRTH <u>Dec. 25, 1913</u>	9. AGE (In years last birthday) <u>52</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>unknown</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
				17. INFORMANT ADDRESS <u>William Brown, Jr. - son 807 N. Gilmore St.</u>	
18. <u>00217 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Malnutrition and severe dehydration.</u> (B) <u>Far advanced pulmonary tuberculosis</u> (C) _____	
INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>December 13, 1965</u> to <u>January 21, 1966</u> , that (I) (we) last saw the deceased alive on <u>January 21, 1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>R. Theodore</u>				23B. DATE SIGNED <u>January 21, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>Roger Theodore</u>				23D. ADDRESS M.D. <u>1415 Division St. - Baltimore 17, Maryland</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/29/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn Cemetry</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS <u>Adolphus Halstead 1206 W North Ave</u>	



1
C. 350

66 00941

BALTIMORE CITY HEALTH DEPARTMENT

66 00941

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Horace Cheatham

2. DATE AND HOUR PRONOUNCED DEAD

1/23/66 1:45 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1143 Myrtle Ave.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

9. AGE (In years last birthday)

31

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

Mattie Cheatham

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

215-30-8544

17. INFORMANT

ADDRESS

Mrs Mattie Cheatham 2035 N Calber St

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cirrhosis of liver

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK

NOT WHILE AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

1/23/66

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

1/28/66

23C. NAME of CEMETERY or CREMATORY

Mt Auburn Cemetery

23D. LOCATION

Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Adolphus Halstead 1206 W North Ave

VALLEY FORD

446 (CONT)

USN

John R. [unclear]

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Raymond Guy Clem

2. DATE AND HOUR OF DEATH

28 1/26/66 2:08 AM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1154 Ward Street 21230

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

Widower

8. DATE OF BIRTH

7-20-1895

9. AGE (In years
last birthday)

70

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Blacksmith

10B. KIND OF BUSINESS OR INDUSTRY

Horse Shoeing

11. BIRTHPLACE (State or foreign country)

Maryland, Frederick Co.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles-deceased Clem

14. MOTHER'S MAIDEN NAME

(Daughter) Anna Mary -deceased TURNER

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

12-3248

17. INFORMANT'S NAME AND ADDRESS

Records: BCH-4940 Eastern Avenue 21224 21123

18.

465 X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Severe Chronic Lung Disease UNKNOWN

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
WorkNot While
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/19/66 to 1/26/66.
that (I) (we) last saw the deceased alive on 1/25/66 and that in my (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

R. Stuart Weeks, M.D.

M.D.

Attending
Phys.Med.
DirectorStaff
Phys.

23B. DATE SIGNED

1/26/66

23C. PHYSICIAN'S
NAME (Type)

R. Stuart Weeks

M.D.

23D. ADDRESS Eastern Avenue, Baltimore, Maryland

Baltimore City Hosp.

24A. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

JAN 29-1966 SAT

24C. NAME OF CEMETERY or CREMATORY

Baltimore City Cemetery

24D. LOCATION

Brooklyn & Co. Hwy

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 28 1966

25B. NAME OF REGISTRAR

C. E. Evans

25C. FUNERAL DIRECTOR

Curtis E. Evans ADDRESS 1400 S. Charles St 21230

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Documentary evidence

Some American Long Distance

11/10/10

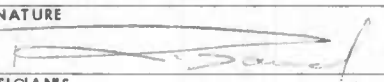
W. J. Hunt & Co. N.Y.

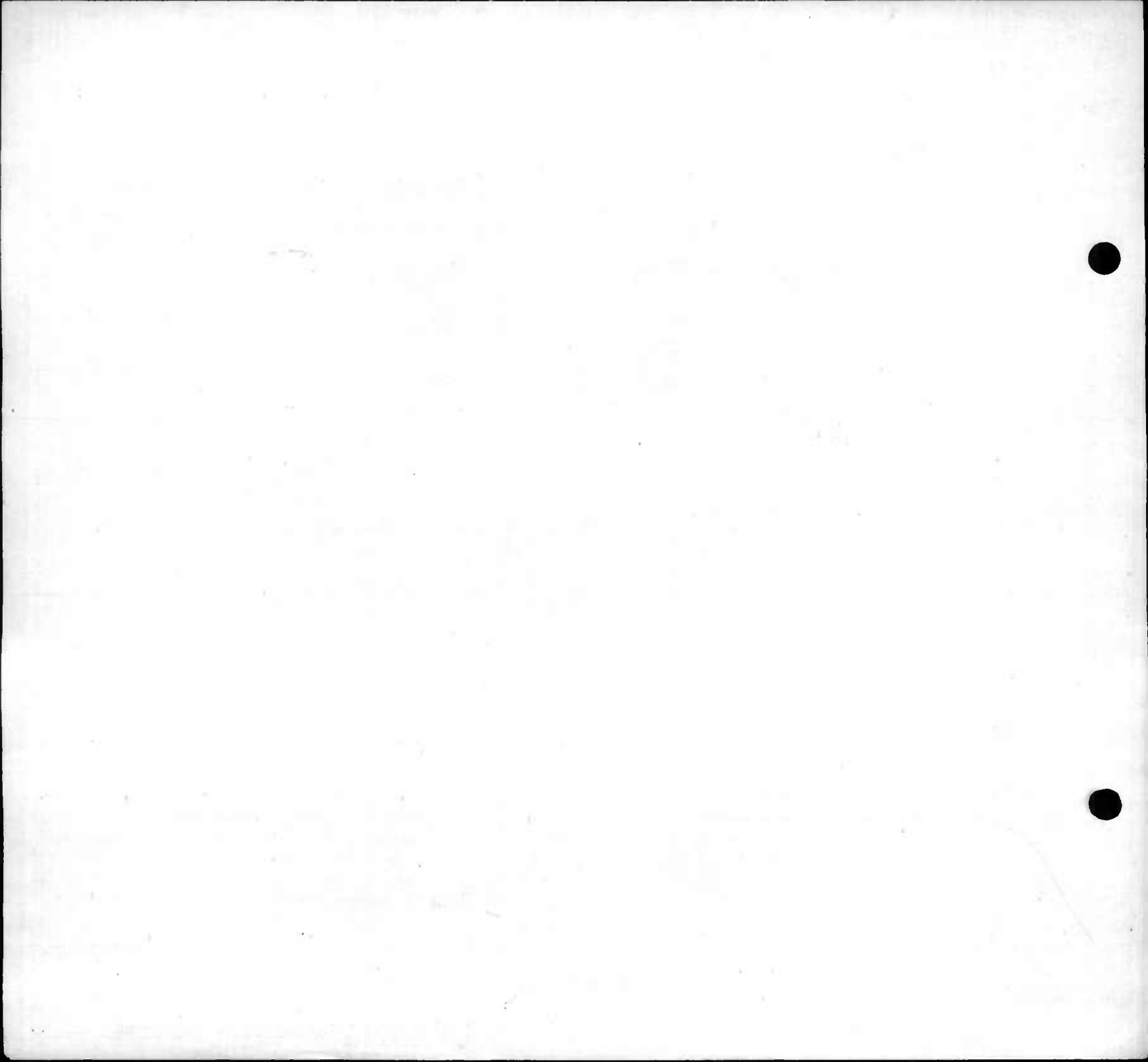
27th Street N.Y.C.

Baltimore City Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 00943</u>	
BIRTH NO. <u>66 00943</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>David Smith</u>			2. DATE AND HOUR OF DEATH <u>January 25, 1966</u> <u>6:00a.m.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland 21217</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>14-02</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1710 Etting Street</u>		
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>unknown</u>	8. DATE OF BIRTH <u>unknown</u>	9. AGE (In years, last birthday) <u>35</u>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (State or foreign country) <u>unknown</u>	
12. CITIZEN OF WHAT COUNTRY? <u>unknown</u>			13. FATHER'S NAME <u>unknown</u>		
14. MOTHER'S MAIDEN NAME <u>unknown</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>Mrs. Regina Walker-sister</u> ADDRESS <u>233-3664</u> <u>641 Rosedale St.</u>		
18. <u>450.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Severe malnutrition and dehydration</u>			19. CAUSE OF DEATH (A) <u>Chronic renal failure</u> DUE TO (B) <u>Arteriosclerosis vascular disease</u> DUE TO (C) _____		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <u>no</u>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>January 19,</u> 19 <u>66</u> to <u>January 25,</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>January 25,</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 			23B. DATE SIGNED <u>January 25, 1966</u>		
23C. PHYSICIAN'S NAME (Type) <u>Andre Rigaud</u>			23D. ADDRESS M.D. <u>1514 Division St.-Baltimore 17, Maryland</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/27/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt Calvary Cemetery</u>	
24D. LOCATION <u>A A County Md</u>		24E. ADDRESS <u>Adolphus Halstead 1206 W North Ave</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1966</u>		25B. NAME OF REGISTRAR <u>Adolphus Halstead</u>		25C. FUNERAL DIRECTOR <u>Adolphus Halstead</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 66 00944	
BIRTH NO. 66 00944										CERTIFICATE OF DEATH	
M.E. CASE NO.										2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Maggie Holmes</i>										Jan. 25, 1966 2 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)										A. STATE B. COUNTY	
1608 Appleton ST.										Maryland 17	
										C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
										Baltimore 15-02	
										D. STREET ADDRESS (If rural, give location)	
										1608 Appleton ST.	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. Under 1 Yr. Months Days	
Female		Colored		Married		SEPT 14 1893		73			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife				None				Jacksonville, MA.		U. S. A.	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Henry Swain						Elizabeth Swain					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS	
No						Warren Holmes				SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH										CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)										INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES											
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan. 1966 to Jan. 25, 1966, that (I) (we) last saw the deceased alive on Jan. 24, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE										23B. DATE SIGNED	
Richard H. Hunt										1/26/66	
23C. PHYSICIAN'S NAME (Type)										23D. ADDRESS	
RICHARD H. HUNT										1607 W. Mulberry Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)	
Burial				1-29-66		Mt Auburn Cem				Balto Md	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR			
JAN 28 1966				C. J. G. G. G.				C. J. G. G. G.			

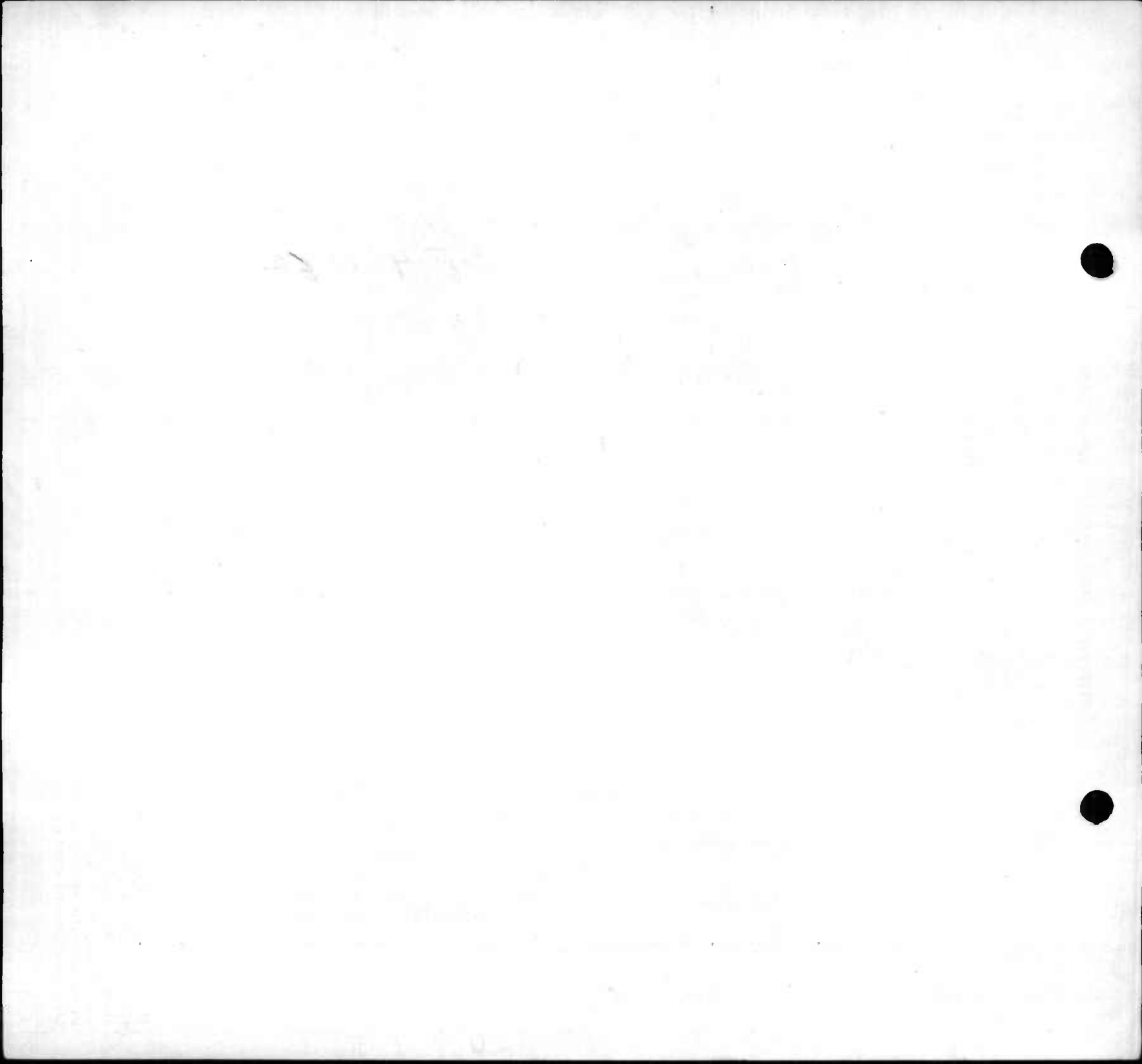
Richardson 2nd
Johnston Adams

Richardson 2nd
Johnston Adams

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

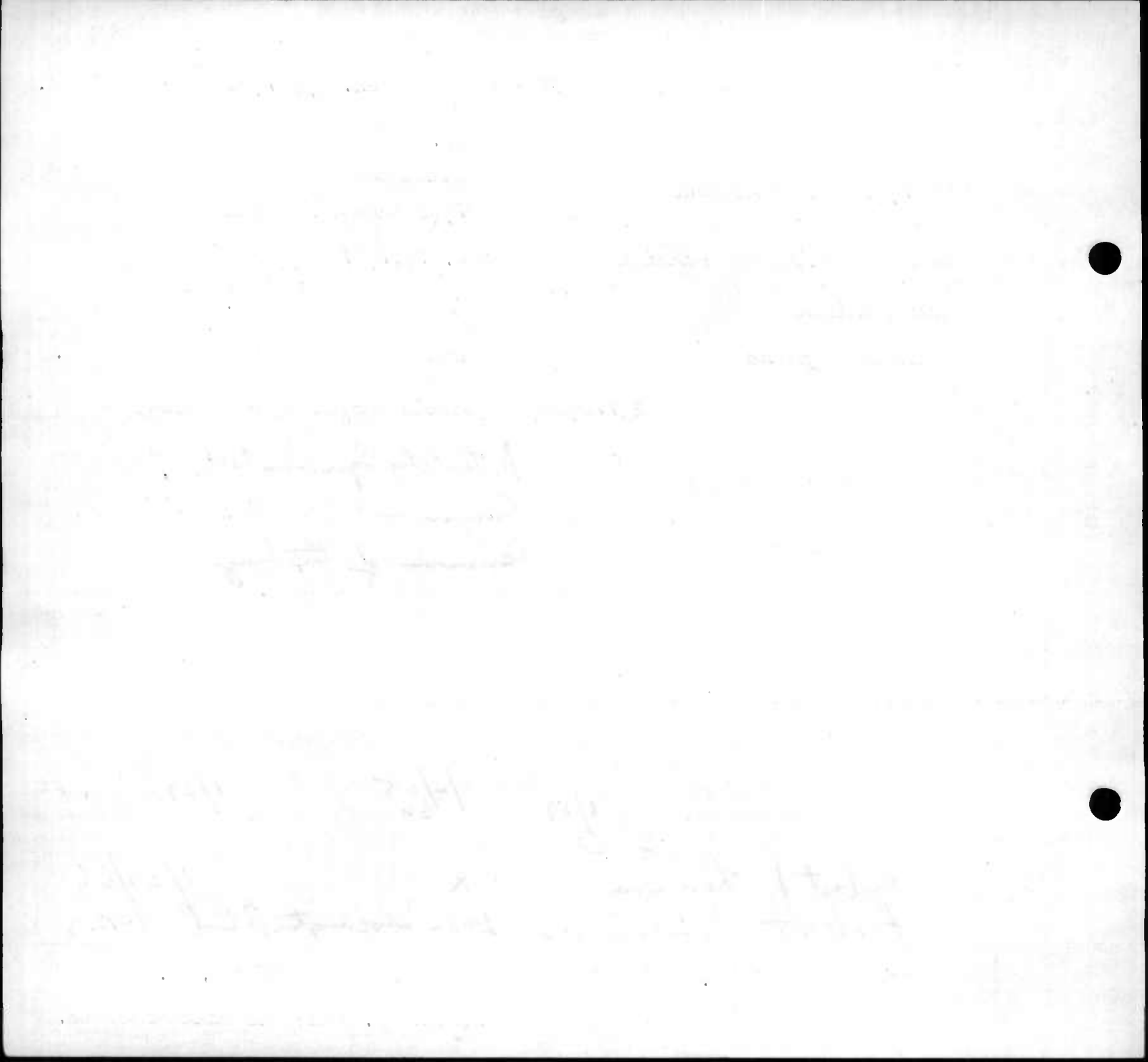
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00945	
66 00945				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		Mary Taylor		1-26-66 3:40 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		Maryland 2201	
South Baltimore General Hosp		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore 21230	
D. STREET ADDRESS (If rural, give location)		713 So. Hanover St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
F.	Negro	M	Sept. 4 1903	62	Unemployed
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Sept 4 - U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Luzanne Pulley		Marie Camper		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No				Verne Lee	
18. 4201 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) ACUTE M.I.		2 HOURS	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO			
ANTECEDENT CAUSES		(B) ARTERIOSCLEROTIC		YEARS	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO CARDIOVASCULAR DISORDER			
(C)					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-26-66 to 1-26-66, that (I) (we) last saw the deceased alive on 1-26-66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Edward S. Hoffman				1/26/66	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Edward S. Hoffman				South Baltimore General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)				24C. NAME OF CEMETERY or CREMATORY	
Burial				Mt Calvary Cent	
24B. DATE				24D. LOCATION (City, town, or county) (State)	
1-31-66				Brooklyn Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 28 1966		Cheryl Wilson		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

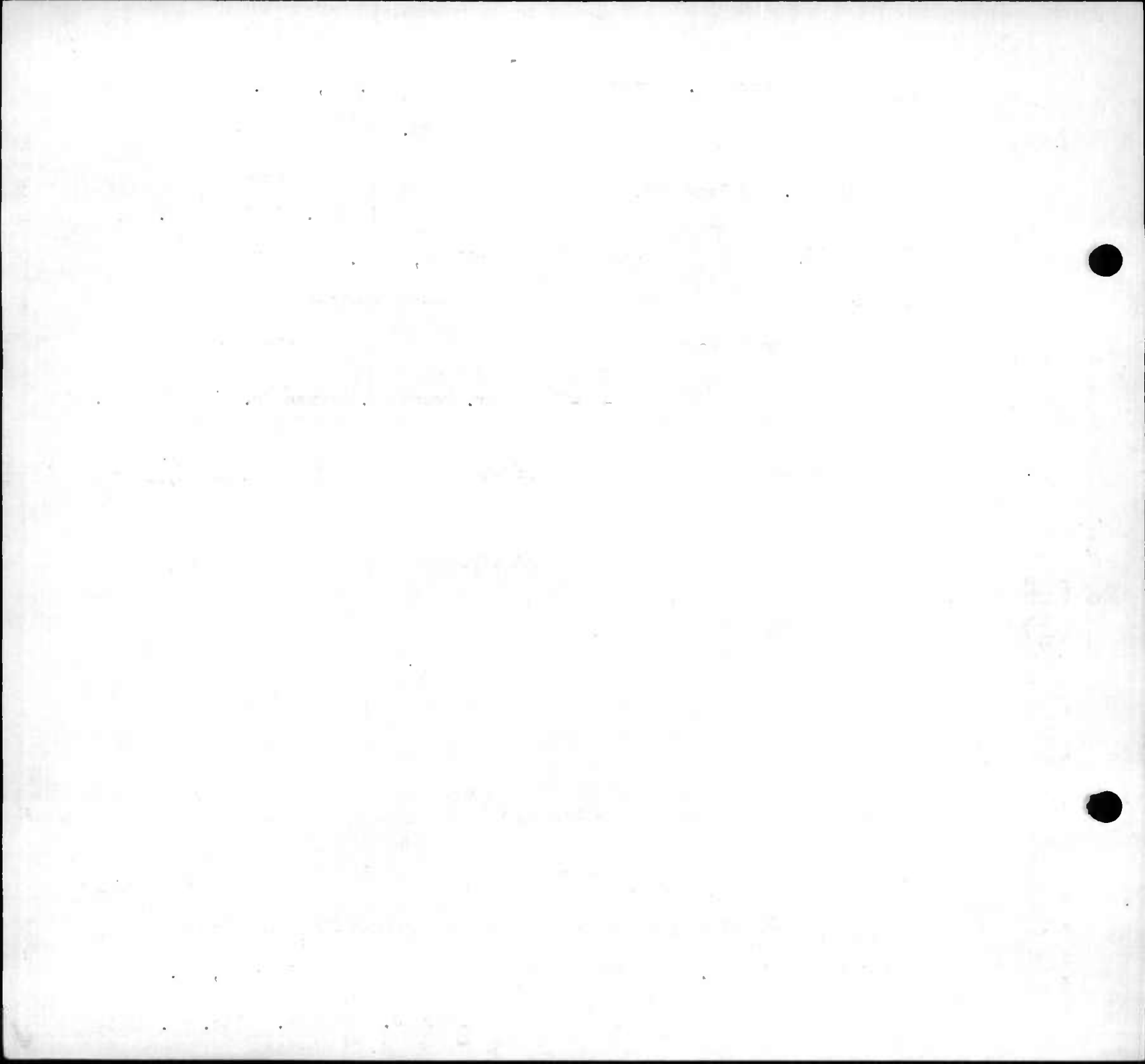
BALTIMORE CITY HEALTH DEPARTMENT				REGISTERED NO. 66 00946	
BIRTH NO. 66 00946		CERTIFICATE OF DEATH		Registered No. 66 00946	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Earl E Eppard</i>		2. DATE AND HOUR OF DEATH <i>Jan. 27, 1966</i> 7 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>25-43</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>1946 Annapolis Road</i>		D. STREET ADDRESS (If rural, give location) <i>1946 Annapolis Road</i>			
5. SEX <i>male</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>Nov. 14, 1921</i>	9. AGE (In years last birthday) <i>44</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Truck Driver</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Marvin Eppard</i>		14. MOTHER'S MAIDEN NAME <i>Maude ?</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WW 2</i>		16. SOCIAL SECURITY NO. <i>231164804</i>		17. INFORMANT <i>Cecelia Napfel Eppard</i>	
18. <i>163X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <i>Metastatic Squamous Cell Carcinoma</i> (B) <i>Carcinoma</i> (C) <i>Carcinoma of the lung</i> INTERVAL BETWEEN ONSET AND DEATH <i>7 months</i>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>1/4/65</i> 19 to <i>1/27</i> 19 <i>66</i> , that (I) (we) lost saw the deceased alive on <i>1/19</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Herbert J. Levickas</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>1/27/66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Herbert J. Levickas</i>		M.D. 23D. ADDRESS <i>2436 Washington Blvd (21230)</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/31/66</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 28 1966</i>		25B. NAME OF REGISTRAR <i>Leonard J. Ruck Inc</i>	
25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc</i>		ADDRESS <i>Baltimore, Md.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 00947					REGISTERED NO. 66 00947		CITY HEALTH DEPARTMENT		
BIRTH NO. 66 00947					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) Laura E. Bowman					2. DATE AND HOUR OF DEATH Jan. 27, 1966. 7 A. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1005 S. Highland Ave.					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 26-09 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1005 S. Highland Ave.				
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH April 29, 1895.	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Howard Short					14. MOTHER'S MAIDEN NAME Lulu Warner				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 220-44-7436		17. INFORMANT ADDRESS Mr. Howard R. Bowman Sr. 8401 Glen Rd. #34				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) DUE TO HYPERTENSION (B) DUE TO (C) DUE TO DIABETES MELLITUS INTERVAL BETWEEN ONSET AND DEATH 34 YEARS 10 YEARS									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1960 to 12/17/65 19 that (I) (we) last saw the deceased alive on 12/17/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Benj. B. Moses, M.D.					23B. DATE SIGNED 1/28/66				
23C. PHYSICIAN'S NAME (Type) BENJ. B. MOSES, M.D.					23D. ADDRESS 448 N. LUZERNE AVE. BALTO. 24, MD.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/31/66.		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 28 1966			25B. NAME OF REGISTRAR Leonard J. Ruck Inc.		25C. FUNERAL DIRECTOR ADDRESS Balto. Md. 21214				



1

66 00918

BALTIMORE CITY HEALTH DEPARTMENT

66 00918

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROY J. ROGERS (Roger)

2. DATE AND HOUR PRONOUNCED DEAD

January 27, 1966 9:25 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Balto.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

-1905 E. - 30th St. 360 Academy Rd.

5. SEX M
white6. RACE W
male7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married

8. DATE OF BIRTH

June 20, 1916

9. AGE (in years
last birthday)
49If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Louisiana

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

Joseph X. Rogers

14. MOTHER'S MAIDEN NAME

Eugene ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWII

16. SOCIAL
SECURITY NO.

215095754

17. INFORMANT

Mrs. Fay Mary K. Rogers-- Same

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?
yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
1-27-6623A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1/31/66

23C. NAME of CEMETERY or CREMATORY

Parkwood Cemetery

23D. LOCATION

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

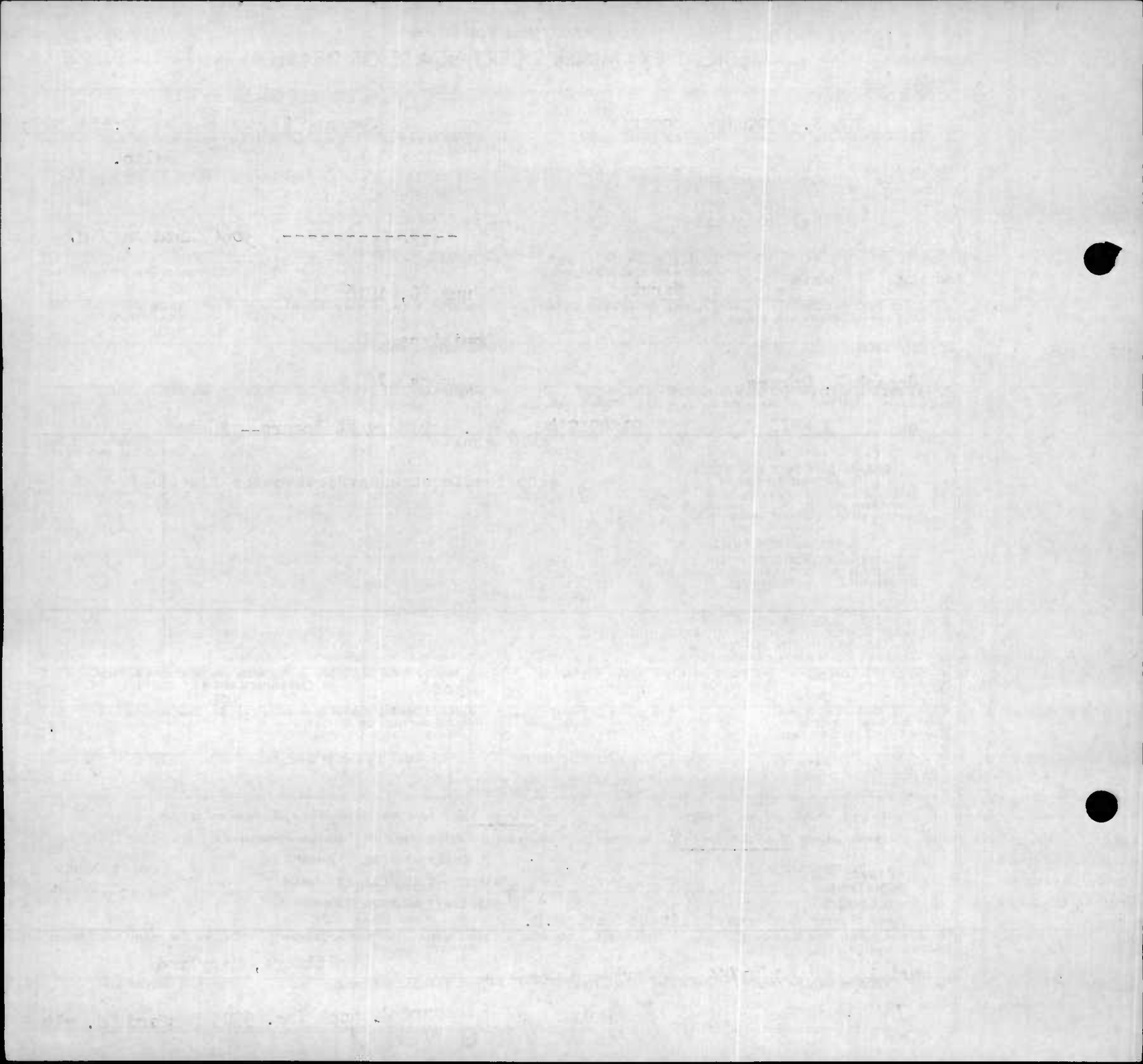
JAN 28 1966

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

Leonard J. Ruck Inc. 5305 Harford Rd. #14

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

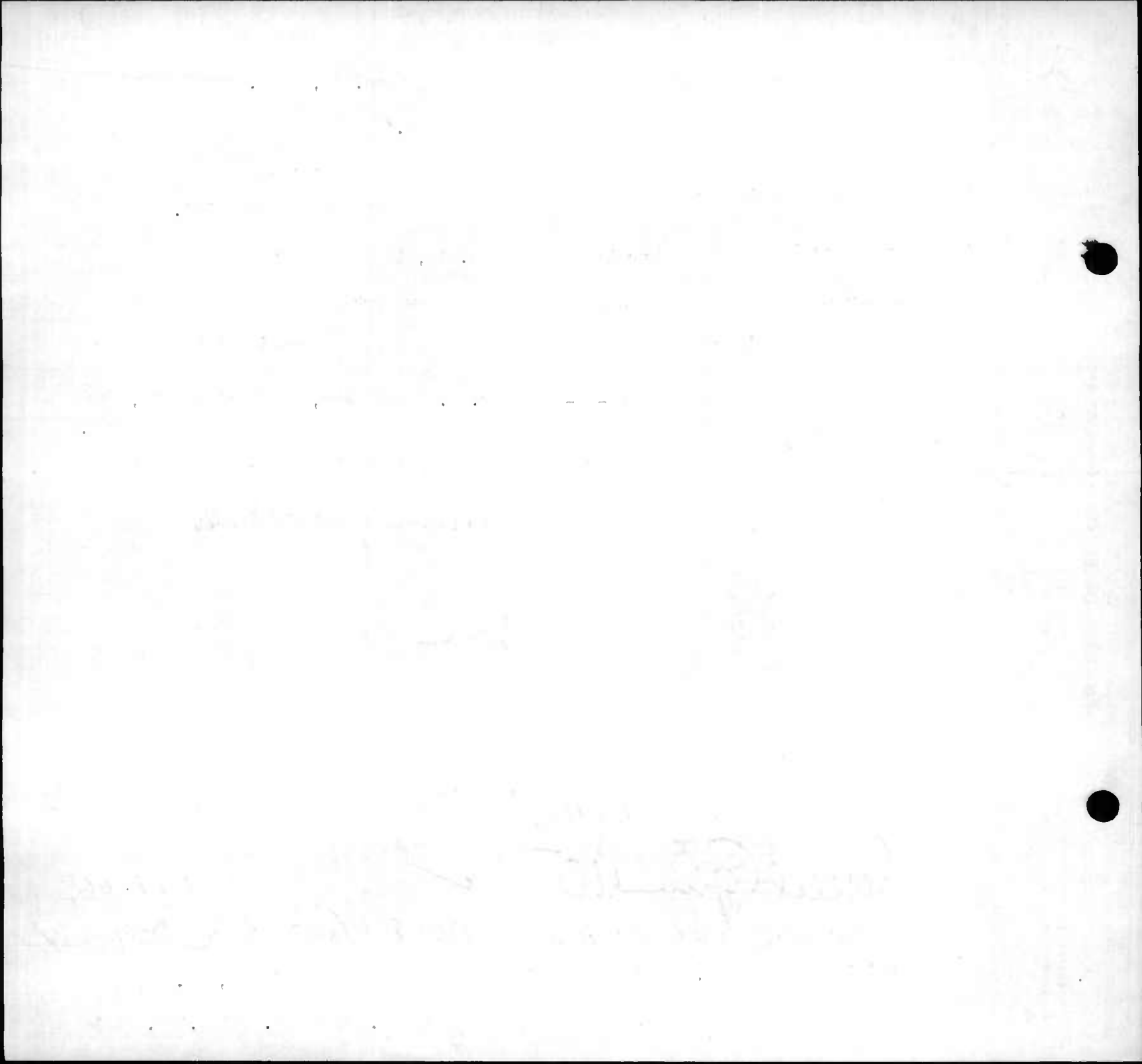
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 66 00949	
BIRTH NO. 66 00949		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Carl H. Schlag, Sr.		2. DATE AND HOUR OF DEATH 1/27/66 9:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital Balto. Md.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto.			
5. SEX M		6. RACE CAU		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH Nov. 30, 1897	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		10B. KIND OF BUSINESS OR INDUSTRY Balto County		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Adolph Schlag				14. MOTHER'S MAIDEN NAME Louise Ruehl			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-01-5619		17. INFORMANT Wilma Schlag (wife)		ADDRESS SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Chronic obstructive airway disease				INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1/3 19 66 to 1/27 19 66 , that (I) (we) last saw the deceased alive on 1/27 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Donald T. Lewers M.D.						23B. DATE SIGNED 1/27/66	
23C. PHYSICIAN'S NAME (Type) DONALD T. LEWERS				23D. ADDRESS Maryland General Hospital M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/29/66.		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 28 1966				25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. ADDRESS 21214	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

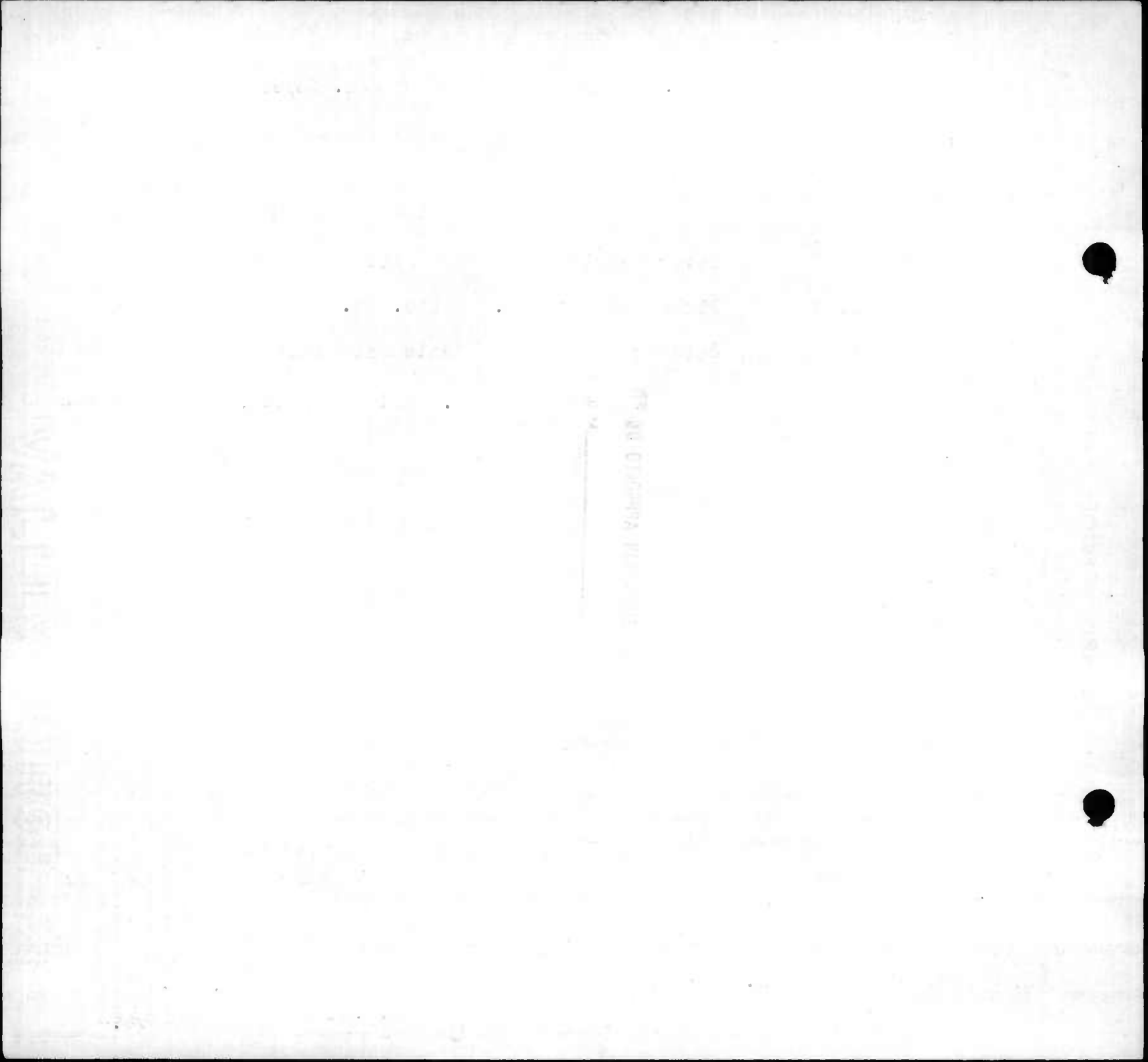
BIRTH NO. 66 00950		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 00950	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Mae Lorretta Rehr			2. DATE AND HOUR OF DEATH Jan. 27, 1966. 7:45 PM M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Gould Nursing Home			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 6101 Loch Raven Blvd.		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Jan. 14, 1899	9. AGE (In years last birthday) 67	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Wilson			14. MOTHER'S MAIDEN NAME Mammie Riely		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-14-3993	17. INFORMANT ADDRESS Mr. H. Frank Rehr, 5816 Leith Walk, #12		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Generalized Metastases (B) Carcinoma of the Gall Bladder (C) INTERVAL BETWEEN ONSET AND DEATH ?					
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 10/5/47 to 1/27/66, that (I) (we) last saw the deceased alive on 1/24/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Samuel Legum M.D.			23B. DATE SIGNED 1-28-66		
23C. PHYSICIAN'S NAME (Type) SAMUEL LEGUM M.D.			23D. ADDRESS 1261 E North Ave. Balto. Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 1/31/66.	24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT. JAN 28 1966		25B. NAME OF REGISTRAR Leonard J. Ruck Inc.	25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Balto. Md. 21214		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 5		BALTIMORE CITY HEALTH DEPARTMENT		REGISTERED NO. 66 00951	
M.E. CASE NO. 66 00951		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Theodore A. Balsamo		2. DATE AND HOUR OF DEATH Jan. 26/66 6:00 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE 4207 Flowerton Rd 8. COUNTY Baltimore			
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married	
8. DATE OF BIRTH March 9/11		9. AGE (in years last birthday) 54		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10B. KIND OF BUSINESS OR INDUSTRY Globe Products Co.		11. BIRTHPLACE (State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME late Anthony Balsamo		14. MOTHER'S MAIDEN NAME Mamie Palmisano	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 05 07 6440		17. INFORMANT ADDRESS Mrs. Mamie Provenza, 4207 Flowerton RD	
18. 4 20.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) acute myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coronary artery occlusion		CAUSE OF DEATH acute myocardial infarction Coronary artery occlusion		INTERVAL BETWEEN ONSET AND DEATH Sudden	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 13 1958 to Jan 26, 1966 , that (I) was lost saw the deceased alive on Oct 11, 1965 and that in my own opinion death occurred on the date and hour and from the causes stated above. (I) was did (did not) view the body after death. Refused					
23A. SIGNATURE Harry L. Knipp		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1-28-66	
23C. PHYSICIAN'S NAME (Type) HARRY L. KNIPP		M.D. 23D. ADDRESS 4116 Edmondson Ave Baltimore 29, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan. 31/66		24C. NAME OF CEMETERY OR CREMATORY New Cathedral	
24D. LOCATION (City, town, or county) Baltimore 29, Md.		24E. STATE Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 28 1966		25B. NAME OF REGISTRAR Witzke F.D.		25C. FUNERAL DIRECTOR ADDRESS 4101 Edmondson Ave.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)R.
ALEXANDER KAMMER

2. DATE AND HOUR PRONOUNCED DEAD

January 27, 1966

9:55 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 28

D. STREET ADDRESS (If rural, give location)

6515 Frederick Rd.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

Feb. 25/11

9. AGE (In years
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Rent Collector

10B. KIND OF BUSINESS OR INDUSTRY

Real Estate Co.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Ferdinand Hammer KAMMER

14. MOTHER'S MAIDEN NAME

Catherine Fahey

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

KAMMER

ADDRESS

Miss Catherine Hammer, 6515 Frederick Rd

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breiteneker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-27-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

burial

23B. DATE

Jan. 29/66

23C. NAME of CEMETERY or CREMATORY

New Cathedral

23D. LOCATION

(City, town, or county)

Balto. Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JAN 28 1966

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

Witzke F.D. 4101 Edmondson Ave

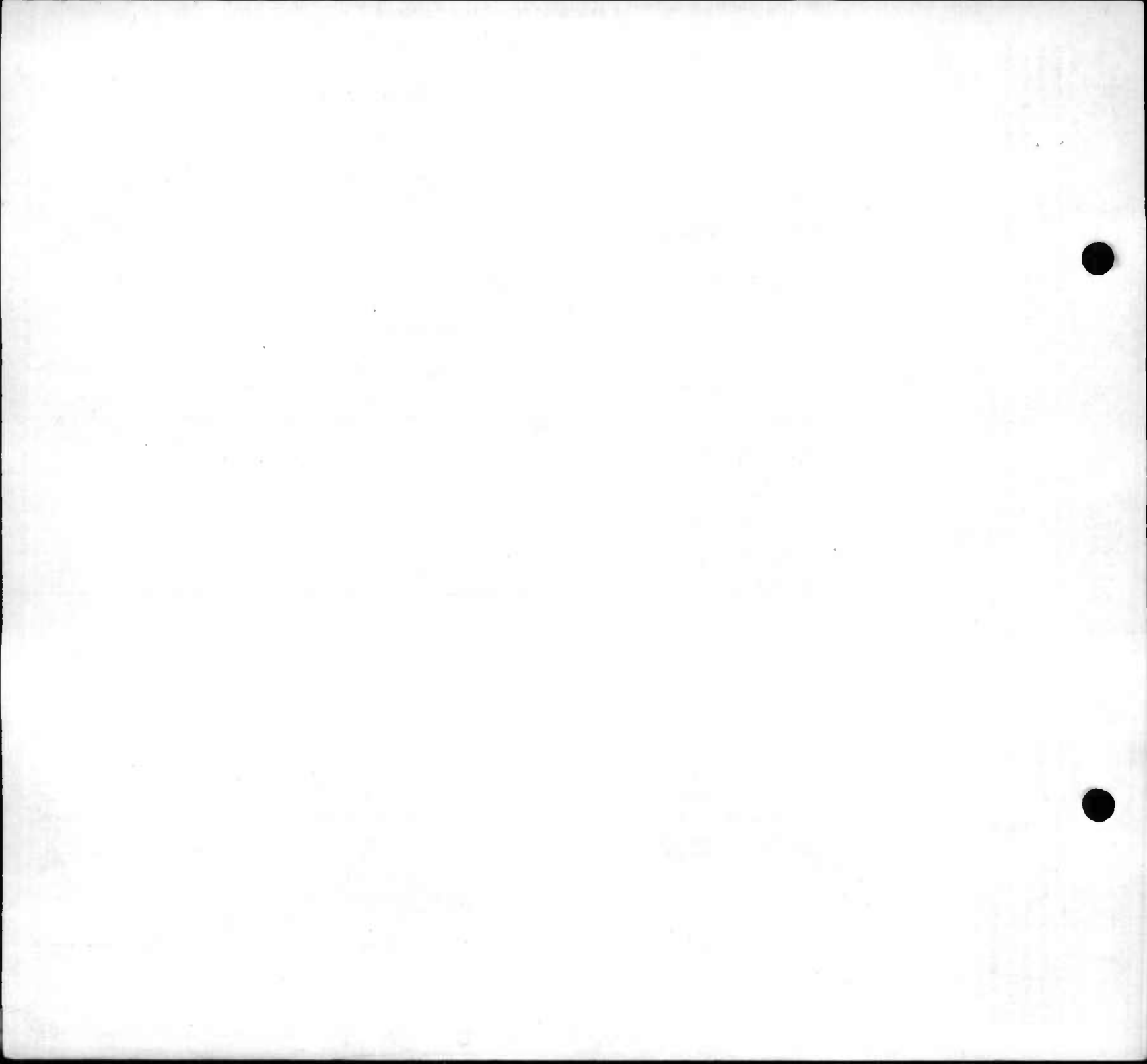
ADDRESS

U.S. 153 C.P.

FUNERAL DIRECTOR: IMPORTANT

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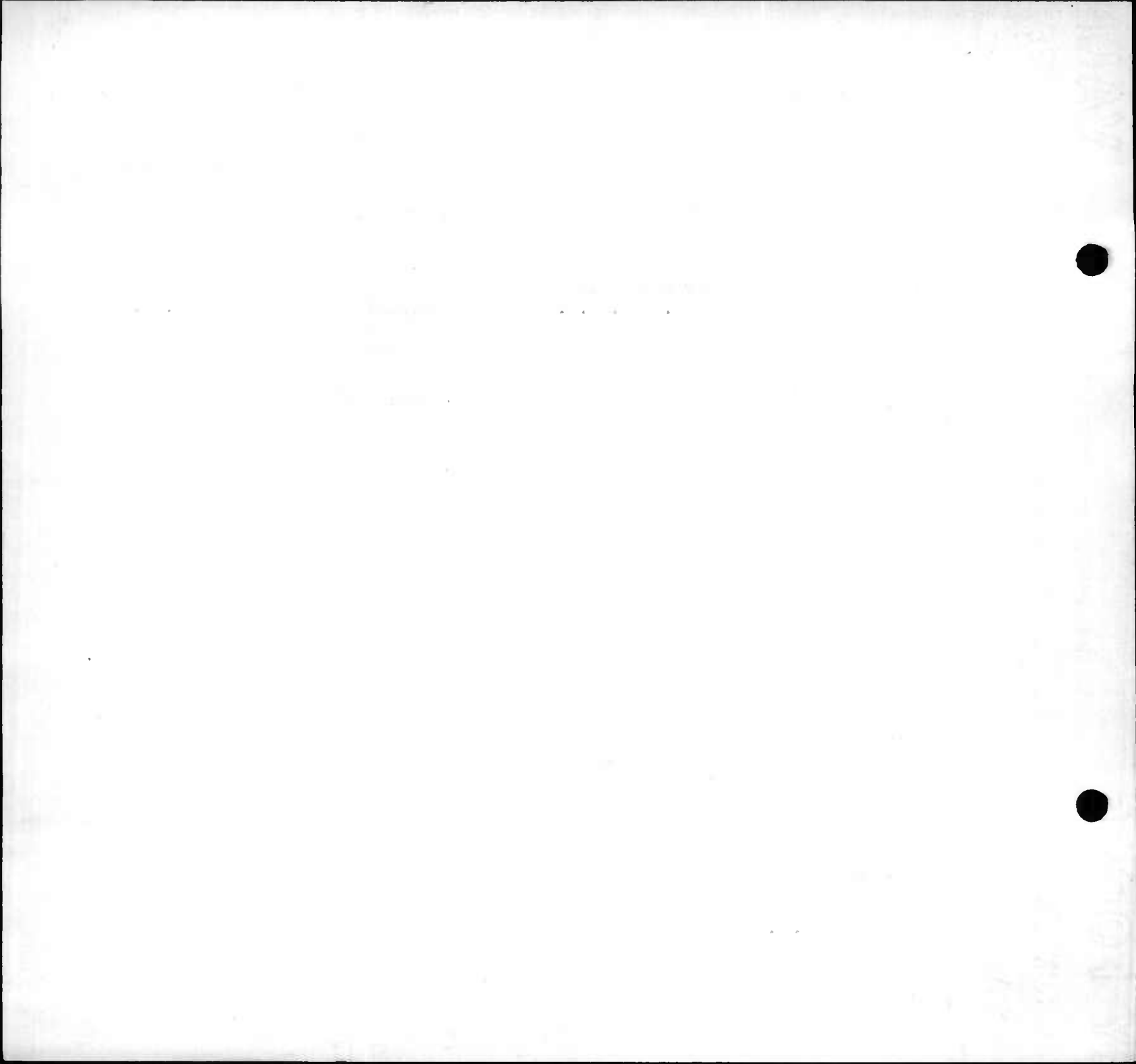
BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 66 00953					CERTIFICATE OF DEATH					Registered No. 00953				
M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) <u>La France Margaret</u>					2. DATE AND HOUR OF DEATH <u>1/27/66 3:28</u> <u>A.</u> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u>					A. STATE <u>Maryland</u>					B. COUNTY <u>22-02</u>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>									
					D. STREET ADDRESS (If rural, give location) <u>401 W. Pratt St.</u>									
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>M.</u>		8. DATE OF BIRTH <u>Dec. 25/94</u>		9. AGE (In years last birthday) <u>71</u>		10. Under 1 Yr. Months: Days		11. Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>					10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>					11. BIRTHPLACE (State or foreign country) <u>England</u>				
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					13. FATHER'S NAME <u>Unknown</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT <u>Raymond La France</u> ADDRESS <u>401 W. Pratt St.</u>				
18. <u>473X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)										CAUSE OF DEATH <u>Pneumonia</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.										INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>ASCD.</u>														
19A. DATE OF OPERATION <u>0 0</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>0</u>					20A. AUTOPSY? (Yes or No) <u>0</u>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>6</u>				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>0</u>					21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work					21F. HOW DID INJURY OCCUR? <u>0</u>				
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 26</u> 19 <u>66</u> to <u>Jan 27</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Jan 27</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <u>E. Ann Robinson</u>										23B. DATE SIGNED <u>1/27/66</u>				
23C. PHYSICIAN'S NAME (Type) <u>E. Ann Robinson</u>										23D. ADDRESS <u>University Hospital</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					24B. DATE <u>Jan. 28/66</u>					24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>				
24D. LOCATION (City, town, or county) (State) <u>Baltimore</u>					25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1966</u>					25B. NAME OF REGISTRAR <u>W. H. Edmondson</u>				
25C. FUNERAL DIRECTOR <u>W. H. Edmondson</u>					25D. ADDRESS <u>401 Edmondson</u>									



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

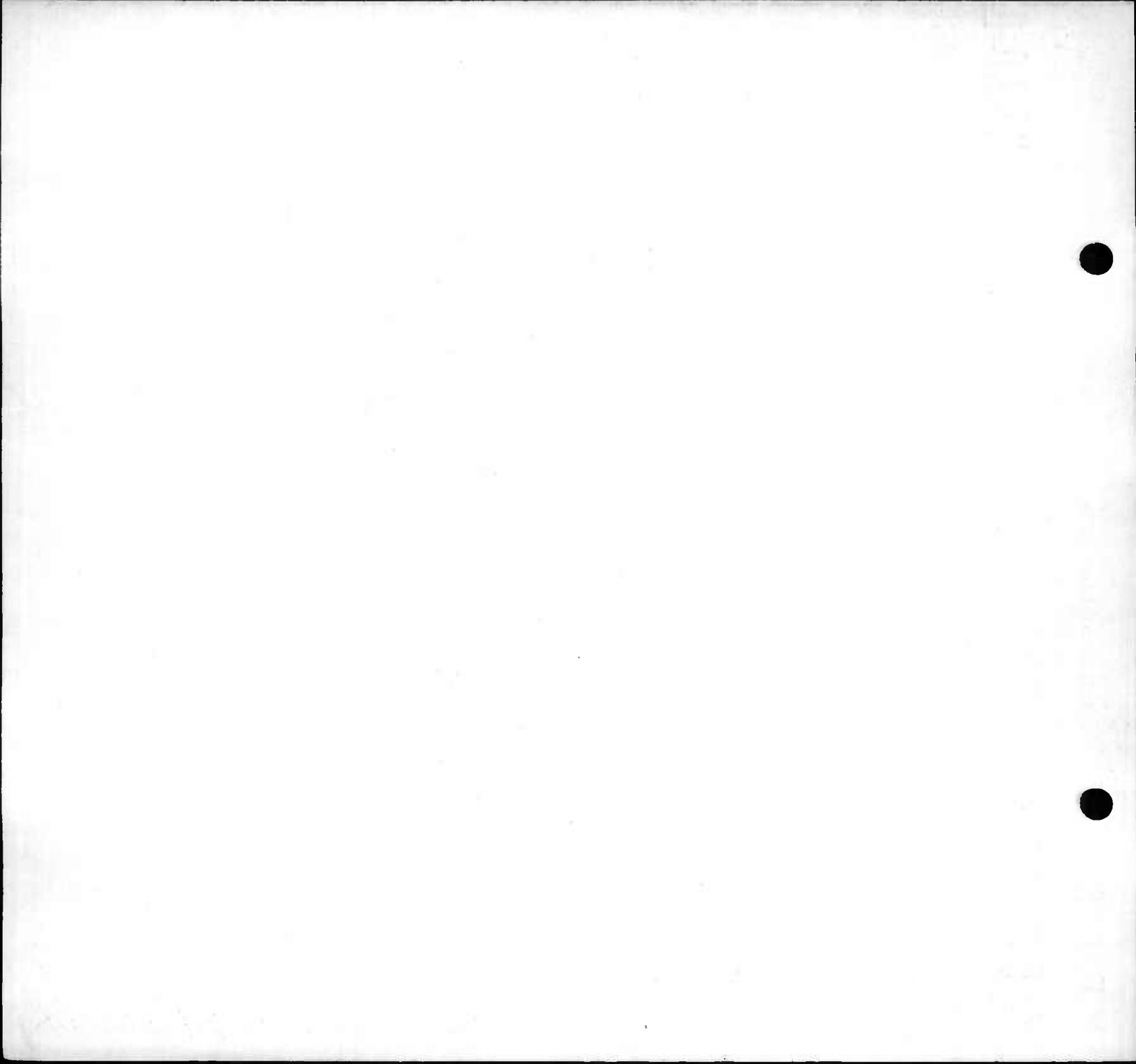
BIRTH NO. <u>66 00954</u>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. <u>66 00954</u>	
M.E. CASE NO. <u>1</u>					
1. NAME OF DECEASED (Type or Print) <u>WALLACE COTTRELL</u>			2. DATE AND HOUR OF DEATH <u>1-21-66</u> <u>6:40 AM</u> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNIVERSITY HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>7403</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Spring Grove St. Hosp</u> D. STREET ADDRESS (If rural, give location) <u>1213 Wall Street</u>		
5. SEX <u>M</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>divorced</u>	8. DATE OF BIRTH <u>1894</u>	9. AGE (In years last birthday) <u>71</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSTITUTIONALIZED SINCE 1923</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Breakman for B. & O. R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>					
13. FATHER'S NAME <u>unknown</u>			14. MOTHER'S MAIDEN NAME <u>unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unknown</u>			16. SOCIAL SECURITY NO. <u>unknown</u>		
17. INFORMANT <u>Records: Spring Grove State Hospital</u>			ADDRESS		
18. <u>157X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> (A) <u>Carcinoma - Ethel.</u> DUE TO (B) <u>Obstetric Jaundice 2°</u> DUE TO <u>Ca Pancre.</u> (C) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>1 mo.</u>					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>NONE</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) <u>1 21 66 AM</u>		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> At Work At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1-20</u> 19 <u>66</u> to <u>1-21</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1-21</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>T.M. Hudak</u>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) <u>T.M. HUDAK</u>			23D. ADDRESS M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial Jan. 26 66</u>		24B. DATE <u>Jan. 26 66</u>		24C. NAME OF CEMETERY or CREMATORY <u>London Park</u>	
24D. LOCATION <u>Balto, 29. Ned</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 4966</u>		25B. NAME OF REGISTRAR <u>Robert E. Sullivan</u>		25C. FUNERAL DIRECTOR <u>Walter H. H. O. E. Edmondson</u>	
25D. ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. <u>66 00955</u>					
BIRTH NO. <u>66 00955</u>					2. DATE AND HOUR OF DEATH <u>24</u> <u>7</u> <u>35</u> <u>P.M.</u>					
M.E. CASE NO.										
1. NAME OF DECEASED (Type or Print) <u>Ector, ENOS</u>										
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>38 University Hospital</u>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Ind.</u> B. COUNTY <u>Balto.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto.</u> D. STREET ADDRESS (If rural, give location) <u>821 N. Franklinton Rd.</u>					
5. SEX <u>M</u>	6. RACE <u>col</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>2-4-1900</u>	9. AGE (In years last birthday) <u>65</u>	If Under 1 Yr. Months: Days: Hours: Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retire</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Capas Ector</u>			14. MOTHER'S MARRIAGE NAME <u>Georgia Allen</u>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>2-16-05-7191</u>		17. INFORMANT <u>Dr. C. C. C. 821 Franklinton Rd.</u>				ADDRESS	
18. <u>260X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH <u>Cerebral vascular disease</u> (A) <u>Diabetes mellitus</u> (B) <u>Diabetes mellitus</u> (C) <u>Diabetes mellitus</u>					INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION <u>2</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>17</u> <u>7</u> <u>1966</u> to <u>24</u> <u>7</u> <u>1966</u> , that (I) (we) last saw the deceased alive on <u>24</u> <u>7</u> <u>1966</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <u>Richard P. Norgaard</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <u>24 7 66</u>		
23C. PHYSICIAN'S NAME (Type) <u>RICHARD P. NORGAARD</u>					23D. ADDRESS <u>University Hospital</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-28-66</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt Auburn Cem</u>		24D. LOCATION (City, town, or county) (State) <u>Balto Md</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1966</u>		25B. NAME OF REGISTRAR <u>Rayner Sanders</u>		25C. FUNERAL DIRECTOR <u>217 E. Preston St</u>		ADDRESS				



BIRTH NO.

66 00956

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

66 00956

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

SUSIE

DUNLAP

2. DATE AND HOUR PRONOUNCED DEAD

January 19, 1966 4:30 P.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1600 N. Port Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

6-19-1940

9. AGE (In years
last birthday)

25

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

House Wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Lawrence Jackson

14. MOTHER'S MAIDEN NAME

Mary Carter

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mary Jackson 1622 Port St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot wound of chest
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

House

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

1622 N. Port Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
1 19 66 4:00P

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot during argument

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-20-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1-24-66

23C. NAME of CEMETERY or CREMATORY

Mt Auburn Cem Balto

23D. LOCATION

(City, town, or county)

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

JAN 28 1966

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

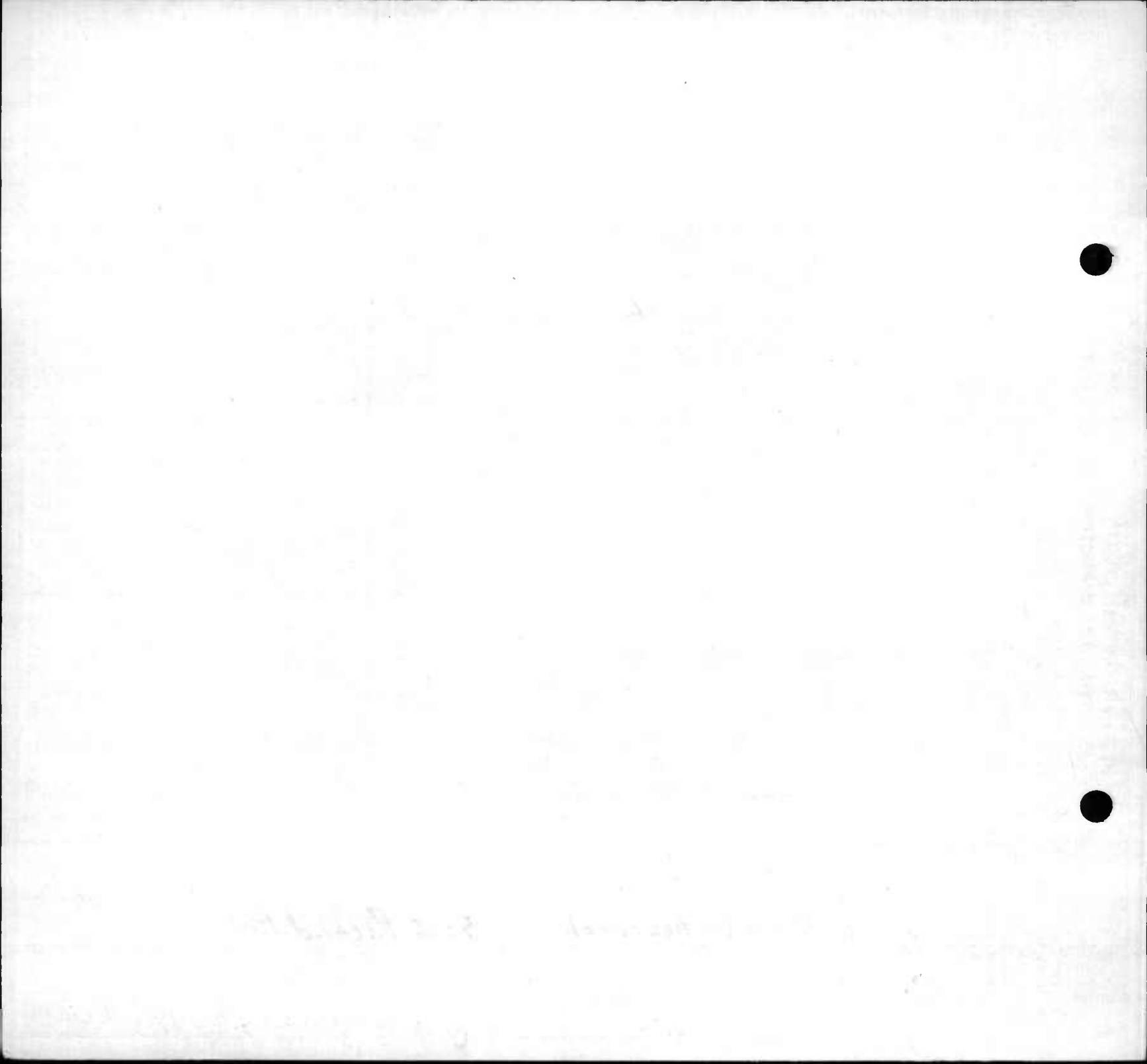
Rayner Sanders 217 E. Preston St

VALLEY FORD
RAB. COUNTY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

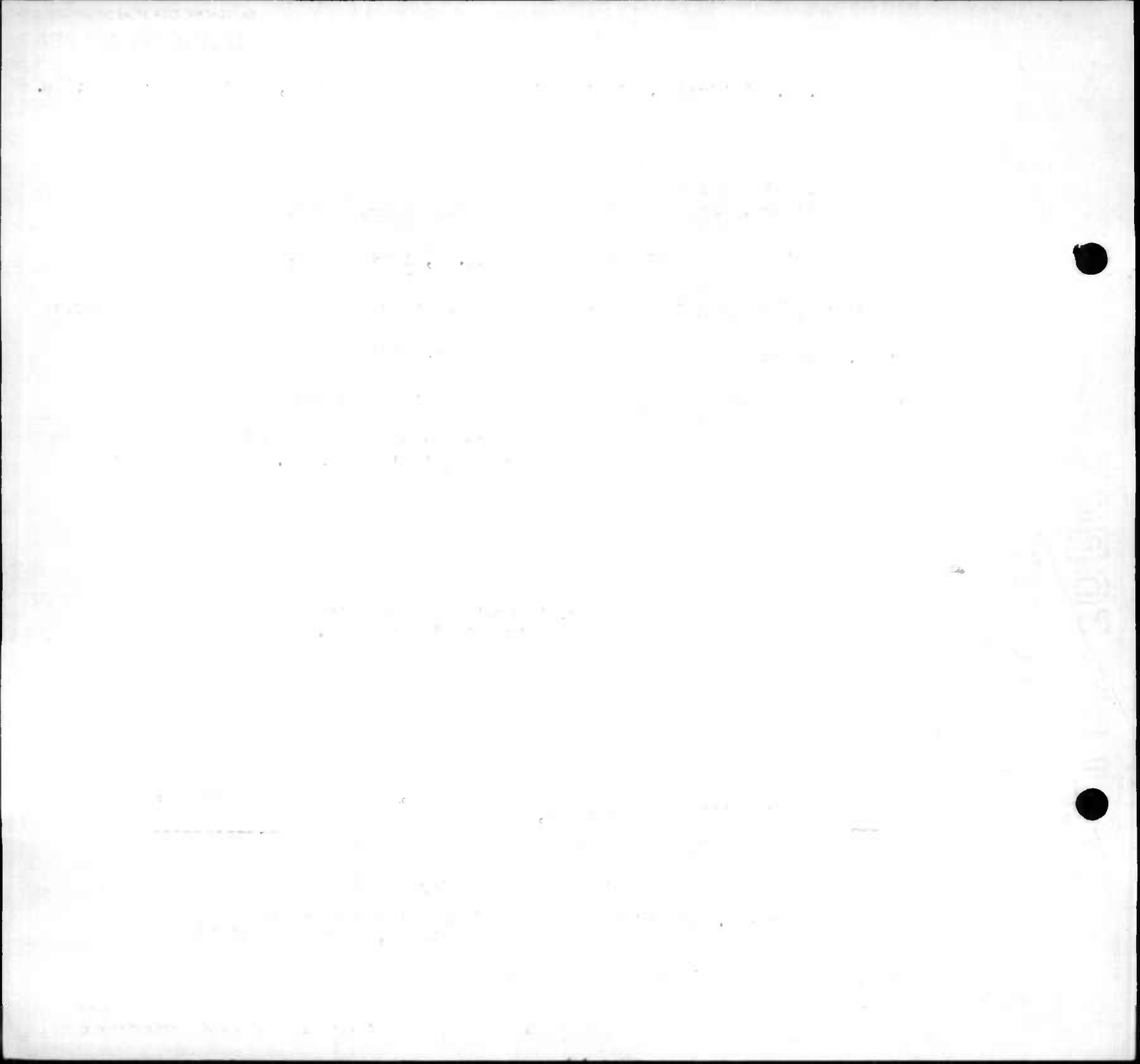
BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. 66 00957					
BIRTH NO. M.E. CASE NO.		66 00957								
1. NAME OF DECEASED (Type or Print) ANNA LAUKIS					2. DATE AND HOUR OF DEATH JAN. 27-1966 1030 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1558 Sheffield Rd					A. STATE MARYLAND					
					B. COUNTY 27-38					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE					
					D. STREET ADDRESS (If rural, give location) 1558 Sheffield Rd					
5. SEX Fem	6. RACE Wh	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 8/17/1888	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sew			10B. KIND OF BUSINESS OR INDUSTRY TAILORING		11. BIRTHPLACE (State or foreign country) LITH		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Joseph VALUNAS					14. MOTHER'S MAIDEN NAME -					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 215-03-5602A		17. INFORMANT Mrs H Morris Whitehurst			ADDRESS		
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ACUTE PULMONARY EDEMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH (A) DUE TO ACUTE PULMONARY EDEMA (B) DUE TO ARTEROSCLEROSIS, CORONARY VESSELS (C) DUE TO					
19A. DATE OF OPERATION 0					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 1-27-1966 to 1-27-1966 and that (I) (we) last saw the deceased alive on 1-27-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
23A. SIGNATURE William G. Helfrich					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 1-28-66		
23D. PHYSICIAN'S NAME (Type) William G. Helfrich					23D. ADDRESS 5006 Roland Ave					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/31/66		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cem			24D. LOCATION Baltimore			
25A. DATE REC'D BY HEALTH DEPT. JAN 28 1966			25B. NAME OF REGISTRAR C. G. F. F. F.			25C. FUNERAL DIRECTOR Thomas J. Kenny Inc			ADDRESS 1600 Hollins	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00958		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 00958	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Mrs. A. Winifred H. Wisniewski			2. DATE AND HOUR OF DEATH January 25, 1966 at 9:45 p.m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Seton Psychiatric Institute 6420 Reisterstown Road Baltimore, Maryland 21215			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 21230 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1412 Andre Street		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Aug. 8, 1904	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife (Factory Worker)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? United States			13. FATHER'S NAME John J. Herbert		
14. MOTHER'S MAIDEN NAME Mary Ruff			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 212-28-4966			17. INFORMANT Hospital Records		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Chronic progressive cerebral atrophy (Pick's Disease).			INTERVAL BETWEEN ONSET AND DEATH 9 years		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Chronic brain syndrome with psychosis (Pick's Disease).			INTERVAL BETWEEN ONSET AND DEATH 9 years		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
21A. DATE OF OPERATION 0		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 25, 1957 to January 25, 1966 , that (I) (we) last saw the deceased alive on January 25, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Walter O. Jahrreiss			23B. DATE SIGNED January 25, 1966		
23C. PHYSICIAN'S NAME (Type) Walter O. Jahrreiss			23D. ADDRESS 6420 Reisterstown Road Baltimore, Maryland 21215		
24A. BURIAL CREMATION, REMOVAL (Specify) Buried		24B. DATE 1/29/66		24C. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery, Md.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 28 1966			
25B. NAME OF REGISTRAR Charles E. Stevens		25C. FUNERAL DIRECTOR Charles E. Stevens Funeral Home, Inc.			
25D. ADDRESS 1500 E. Fort Avenue					



1
0-253

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

66 00959

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

66 00959

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

THOMAS N. OXENDINE Sr.

2. DATE AND HOUR PRONOUNCED DEAD

January 26, 1966

11:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

117 N. Broadway

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

117 N. Broadway

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Separated

8. DATE OF BIRTH

Oct. 8- 1901

9. AGE (In years
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired, Maintenance

10B. KIND OF BUSINESS OR INDUSTRY

Church Home & Hosp.

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Oscar Oxendine

14. MOTHER'S MAIDEN NAME

Florence Oxendine

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes, Army 1919-1921

16. SOCIAL
SECURITY NO.

239-16-7929 Son, Thomas N. Oxendine Jr.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH 1920 Merritt Blvd. 21222 Md

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rodiger Breiteneker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-26-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Jan. 28-1966

23C. NAME OF CEMETERY or CREMATORY

Gardens of Faith

23D. LOCATION

(City, town, or county)

(State)

Trumps Mill Rd. Bal. Co Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JAN 28 1966

C.D. #2, F.D. #1

JOHN J. DUDA, Dundalk, Md. 21222

MAIL LETTER BOX

1

66 00960

BALTIMORE CITY HEALTH DEPARTMENT

66 00960

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ELMER E. LEE

2. DATE AND HOUR PRONOUNCED DEAD

January 26, 1966 7:10 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore Dundalk

D. STREET ADDRESS (If rural, give location)

203 Pinewood Road 21222

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

January 31-1915

9. AGE (In years
last birthday)

50

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Pipe Mill, Bethlehem Steel Co.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Oscar Lee

14. MOTHER'S MAIDEN NAME

Emma Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes, Army WWII

16. SOCIAL
SECURITY NO.

218-01-1436

17. INFORMANT

ADDRESS

Wife, Mrs. Marjorie Lee, # 4, H.C.D.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-27-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Jan. 29-1966

23C. NAME of CEMETERY or CREMATORY

Glen Haven,

23D. LOCATION

(City, town, or county)

(State)

Glen Burnie, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JOHN J. DUDA, Dundalk, Md. 21222

VALID FOR 30 DAYS

Handwritten signature

John Smith, Jr.

John Smith, Jr.

John Smith, Jr.

John Smith, Jr.

W 425

66 00961

BALTIMORE CITY HEALTH DEPARTMENT

66 00961

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Clarence L. Wilson

2. DATE AND HOUR PRONOUNCED DEAD

1/24/66

6:20 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2623 Greenmount Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

DECEMBER 20, 1912 53

9. AGE (In years
last birthday)

10. Under 1 Yr. 11 Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

UNKNOWN

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

CHARLES E. WILSON

14. MOTHER'S MAIDEN NAME

ELIZABETH BUCKITE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WW II

16. SOCIAL
SECURITY NO. 4
219-01-6428

17. INFORMANT

ADDRESS

CUNNINGHAM FUNERAL HOME, ALEXANDRIA, VIRGINIA

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Multiple injuries

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

street

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

Frederick Ave. near Taylor Ave.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)
1 24 66 5:40p

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

pedestrian struck by car

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S NAME (Type)
Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/25/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

1/28/66

23C. NAME of CEMETERY or CREMATORY

ARLINGTON NATIONAL CEMETERY

23D. LOCATION

(City, town, or county)

(State)

FORT MEYER, VIRGINIA

24A. DATE REC'D BY HEALTH DEPT.

JAN 31 1966

24B. NAME OF REGISTRAR

Robert E. Spitz, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

HUBBARD FUNERAL HOME, 4107 WILKENS AVE. # 29

WALLACE FORT

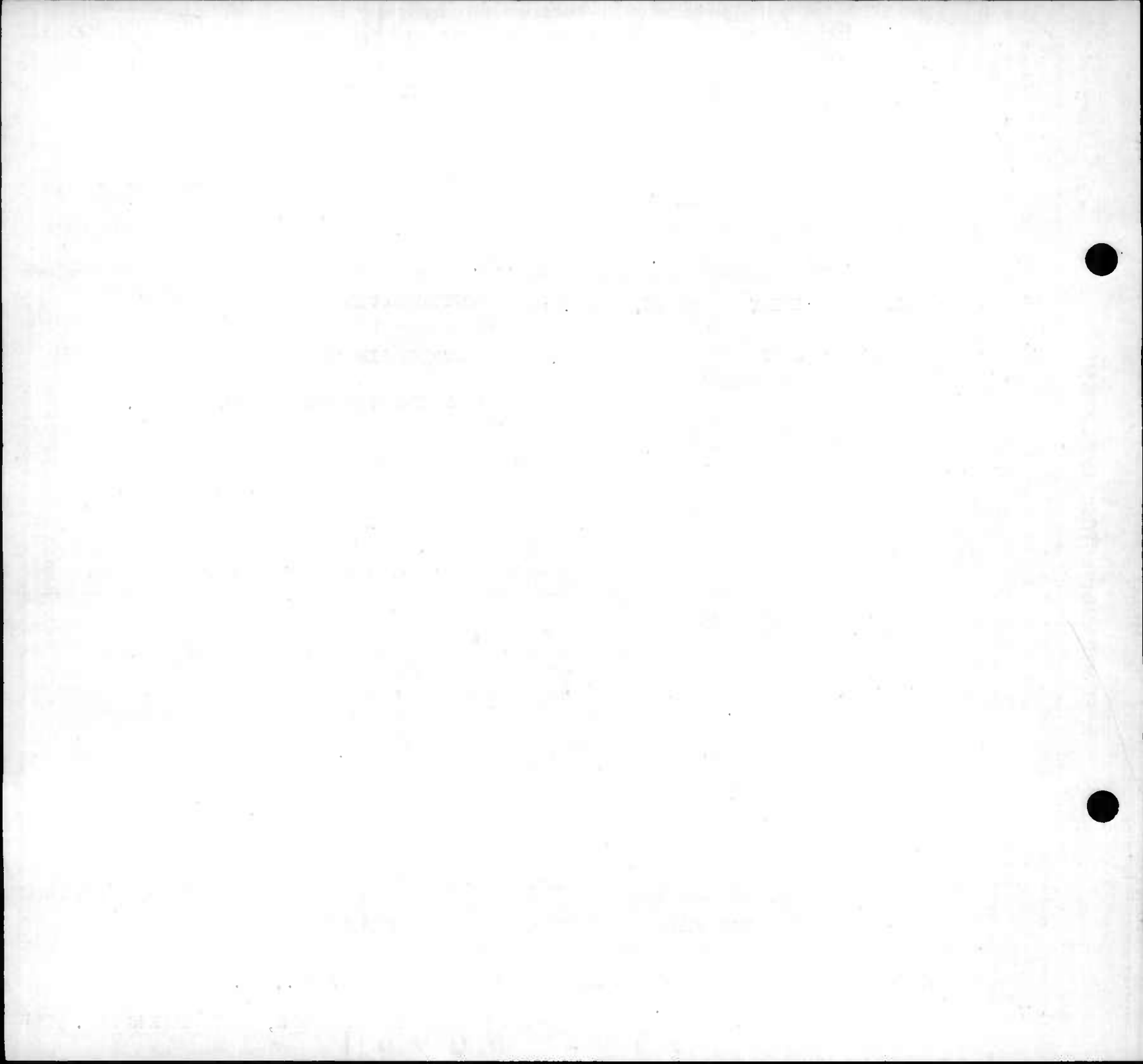
ALL CONTENT

WALLACE FORT

FUNERAL DIRECTOR: IMPORTANT

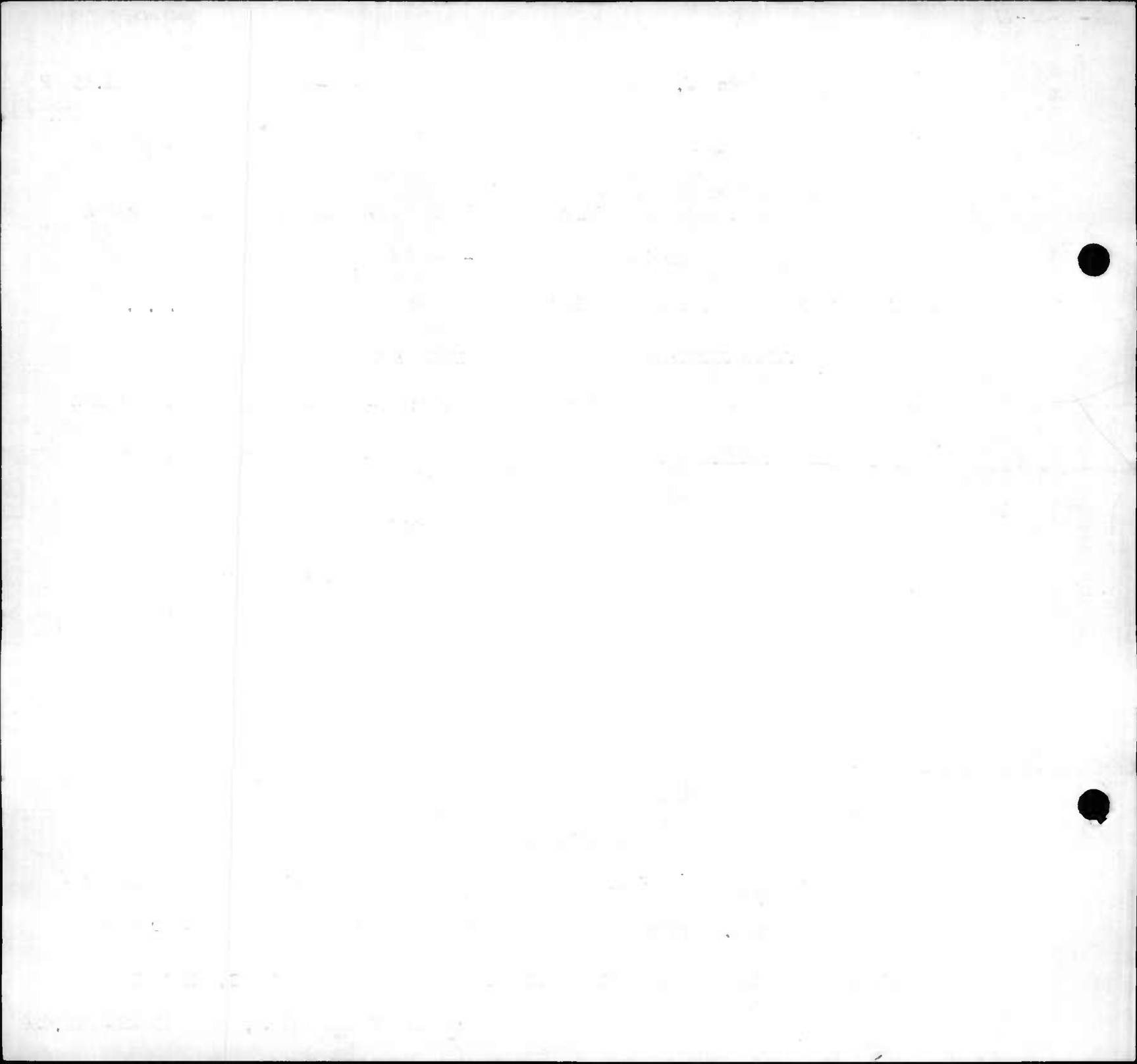
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. 66 00962	
BIRTH NO. 66 00962		M.E. CASE NO.		2. DATE AND HOUR OF DEATH JANUARY 26, 1966	
1. NAME OF DECEASED (Type or Print) EMIL GROSZER					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) HOOD NURSING HOME				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2804 CARROLL STREET 21230	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 9/23/82	9. AGE (In years last birthday) 83	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MACHINIST		10B. KIND OF BUSINESS OR INDUSTRY CROWN, CORK & SEAL		11. BIRTHPLACE (State or foreign country) CZECHOSLOVAKIA	
12. CITIZEN OF WHAT COUNTRY? CZECHOSLOVAKIAN USA					
13. FATHER'S NAME ANDREW GROSZER				14. MOTHER'S MAIDEN NAME KATRINA SIROTKA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216036258		17. INFORMANT ADDRESS CHRISTINA CAMERON 308 HILTON AVE. 21228	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 18. 5-27-11 (A) MYEUMONITIS - PULMONARY EMPHYSEMA & FIBROSIS (B) ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE (C) CLARKIE BRAIN SYNDROME					
MEDICAL CERTIFICATION 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NO 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) NO 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? NO					
22. I certify that (I) (the hospital) attended the deceased from 1/1/66 to 1/26/66 that (I) (we) last saw the deceased alive on 1/26/66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John Shaw 23C. PHYSICIAN'S NAME (Type) JOHN SHAW				23B. DATE SIGNED 1/28/66 M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 1/29/66	
24C. NAME OF CEMETERY or CREMATORY LOUDON PARK CEMETERY				24D. LOCATION (City, town, or county) (State) BALTO., MD.	
25A. DATE REC'D BY HEALTH DEPT. JAN 31 1966		25B. NAME OF REGISTRAR John E. Farley		25C. FUNERAL DIRECTOR ADDRESS HUBBARD FUNERAL HOME, 4107 WILKENS AVE. #29	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

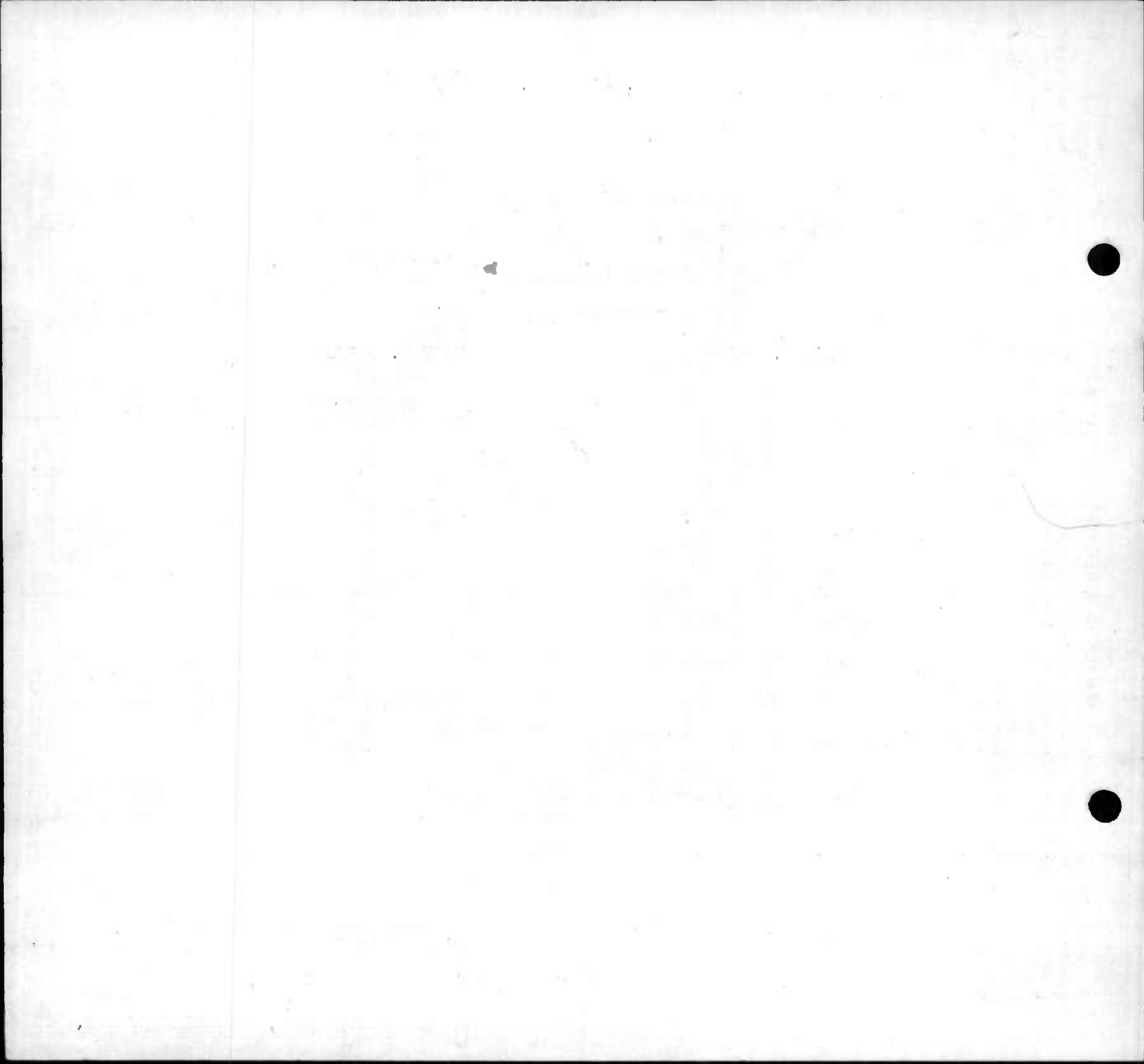
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00963	
BIRTH NO. 66 00963		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH 1-25-1966 11.15 P.M.			
1. NAME OF DECEASED (Type or Print) Clyde J. Jarrells					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		A. STATE Maryland B. COUNTY 1-04			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 1001 1/2 South Belnord Avenue 21224			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2-20-1918	9. AGE (In years last birthday) 47	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL WORKER		10B. KIND OF BUSINESS OR INDUSTRY SPARROWS POINT		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME JAMES JARRELLS		14. MOTHER'S MAIDEN NAME IRENE FRYE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224	
18. 581.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Hepato-Renal syndrome (B) chronic cirrhosis (C)		INTERVAL BETWEEN ONSET AND DEATH 3 wks. 1 year	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 1-21-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Postoperative diagnosis for carcinoma		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-21-1965 to 1-25-1966, that (I) (we) lost saw the deceased alive on 1-25-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John R. Burton		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-25-66	
23C. PHYSICIAN'S NAME (Type) John R. Burton		23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/29/66		24C. NAME OF CEMETERY or CREMATORY MEMORIAL BURIAL PARK	
				24D. LOCATION (City, town, or county) WHEELERSBURG, VIRGINIA (State)	
25A. DATE REC'D BY HEALTH DEPT. JAN 31 1966		25B. NAME OF REGISTRAR Robert E. Jarrells		25C. FUNERAL DIRECTOR ADDRESS HOBARD FUNERAL HOME, 4107 WILKENS AVE. #29	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00964		BALTIMORE CITY HEALTH DEPT. CERTIFICATE OF DEATH		Registered No. 66 00964	
1. NAME OF DECEASED (Type or Print) CARTER, GRACE L. (GRACE L. CARTER)		2. DATE AND HOUR OF DEATH 1-26-66 1 2:30 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSP OF MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 15-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1917 N PAULSON ST 21217			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 2-14-1880	9. AGE (In years last birthday) 85	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME DANIEL W. LUTZ		14. MOTHER'S MAIDEN NAME MARY B. BURTON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -----		17. INFORMANT HERBERT (SON) 962 CIRCLE DR.	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Anterior vascular accident; ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Fracture		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-22 19 66 to 1-26 19 66 , that (I) (we) last saw the deceased alive on 1-22 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sahba Rujada M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 1-26-66	
23C. PHYSICIAN'S NAME (Type) ROBERT BLACKMON		23D. ADDRESS LUTHERAN HOSP OF MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/29/66		24C. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEMETERY	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JAN 31 1966			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR HUBBARD FUNERAL HOME, 4107 WILKENS AVE. #29			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 66 00965	
BIRTH NO. 66 00965							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) Bolton, John Robert				2. DATE AND HOUR OF DEATH 1-27-66 6:10pm M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital Baltimore, Maryland 21229				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE Maryland B. COUNTY Balto C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1008 Southridge Road			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 9/15/04	9. AGE (In years last birthday) 62 61	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic		10B. KIND OF BUSINESS OR INDUSTRY Avis Car Rental		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN BOLTON				14. MOTHER'S MAIDEN NAME MARY LONG			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO. 215-05-0705		17. INFORMANT ADDRESS St. Agnes Emergency Room Records Balto. 29, Md			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I Coronary Thrombosis				CAUSE OF DEATH (A) DUE TO Anticoagulant C.V. disease (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH Suddenly	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Dec 1 19 64 to 1-27- 19 66 , that (I) (we) last saw the deceased alive on Dec 22 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE D.C. MacLaughlin				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/28/66	
23C. PHYSICIAN'S NAME (Type) D.C. MacLaughlin				23D. ADDRESS 303 N. Rolling Rd - 21228			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan 31, 1966		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemt		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. FEB 1 1966		25B. NAME OF REGISTRAR P. E. Taylor		25C. FUNERAL DIRECTOR STERLING FUNERAL ESTATE		ADDRESS 8736 Edmondson Av, Catonsville	

John Deere Co. 1950

no Country Copy

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 00966

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 66 00966

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

GROCHOWSKI, James Joseph

2. DATE AND HOUR OF DEATH

January 28, 1966

10:12 a.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Veterans Administration Hospital
3900 Loch Raven Boulevard
Baltimore, Maryland 21218

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

318 South Collington Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
Never Married

8. DATE OF BIRTH

10/27/08

9. AGE (In years last birthday)

57

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Pipe fitter

10B. KIND OF BUSINESS OR INDUSTRY

Air-conditioning unknown

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Frank Grochowski

14. MOTHER'S MAIDEN NAME

Margaret Gardyza

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

8/28/42-11/23/45

16. SOCIAL SECURITY NO.

217-09-0432

17. INFORMANT

VA Hospital Records, Baltimore, Maryland 21218

ADDRESS

18. 163 X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Carcinoma of lung

DUE TO

2 years

(B) Acute & chronic bronchitis

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Tuberculosis, old, bilateral, pulmonary, far-advanced, inactive since 1954

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 25th 19 66 to January 28th 19 66, that (I) (we) last saw the deceased alive on January 28th 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Frederic B. Askin

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

January 28, 1966

23C. PHYSICIAN'S NAME (Type)

FREDERIC

ASKIN

M.D.

23D. ADDRESS

VA Hospital, 3900 Loch Raven Boulevard
Baltimore, Maryland 21218

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1/31/66

24C. NAME OF CEMETERY or CREMATORY

Most Holy Redeemer Cemetery

Baltimore, Maryland

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

FEB 1 1966

25B. NAME OF REGISTRAR

George A. Weber

25C. FUNERAL DIRECTOR

George A. Weber - 705 S. Ann St. #21231

ADDRESS

[The body of the document contains extremely faint, illegible text, likely bleed-through from the reverse side. The text is organized into several paragraphs and possibly a list or table, but the specific content cannot be discerned.]

FUNERAL DIRECTOR: IMPORTANT

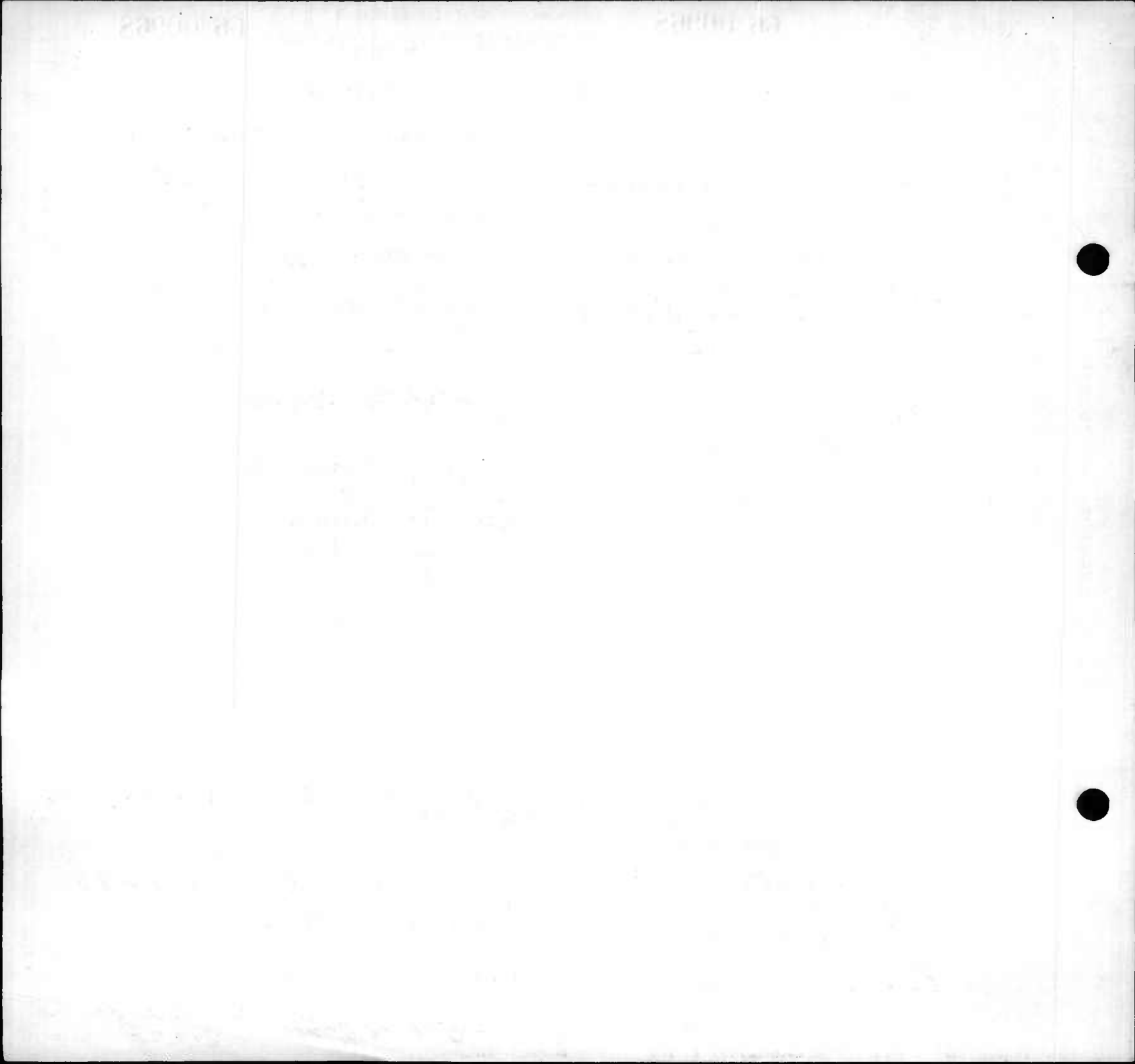
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
66 00967					CERTIFICATE OF DEATH					Registered No. 66 00967				
BIRTH NO. M.E. CASE NO.					1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
					JAMES HARVEY STANTON					JANUARY 27, 1966 4:20 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL										A. STATE MARYLAND				
(If not in hospital or institution, give street address or location)										B. COUNTY CAROLINE COUNTY				
5. SEX M										6. RACE W				
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED										8. DATE OF BIRTH 10-16-97				
9. AGE (In years last birthday) 68										10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				
11. BIRTHPLACE (State or foreign country) MARYLAND										12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME JAMES										14. MOTHER'S MAIDEN NAME LAURA CLEAVES				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO										16. SOCIAL SECURITY NO. 217-05-977				
17. INFORMANT Martha Stanton										ADDRESS R.D. Henderson, Md.				
18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) RHEUMATOID ARTHRITIS										INTERVAL BETWEEN ONSET AND DEATH 12 YEARS				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION 2					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) YES				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (if this hospital) attended the deceased from January 23, 1966 to January 27, 1966, that (if we) last saw the deceased alive on January 27, 1966 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.														
23A. SIGNATURE Kenneth E. Mott										23B. DATE SIGNED January 27, 1966				
23C. PHYSICIAN'S NAME (Type) KENNETH E. MOTT										23D. ADDRESS UNIVERSITY HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 1/31/66					24C. NAME OF CEMETERY or CREMATORY Cherry Hill Methodist				
24D. LOCATION Cecil Co. Maryland					24E. NAME OF REGISTRAR GRANT KUNYAN					24F. FUNERAL DIRECTOR HOMER DONAHUE				
25A. DATE REC'D BY HEALTH DEPT. FEB 1 1966					25B. NAME OF REGISTRAR					25C. FUNERAL DIRECTOR NORTH EAST Md				

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

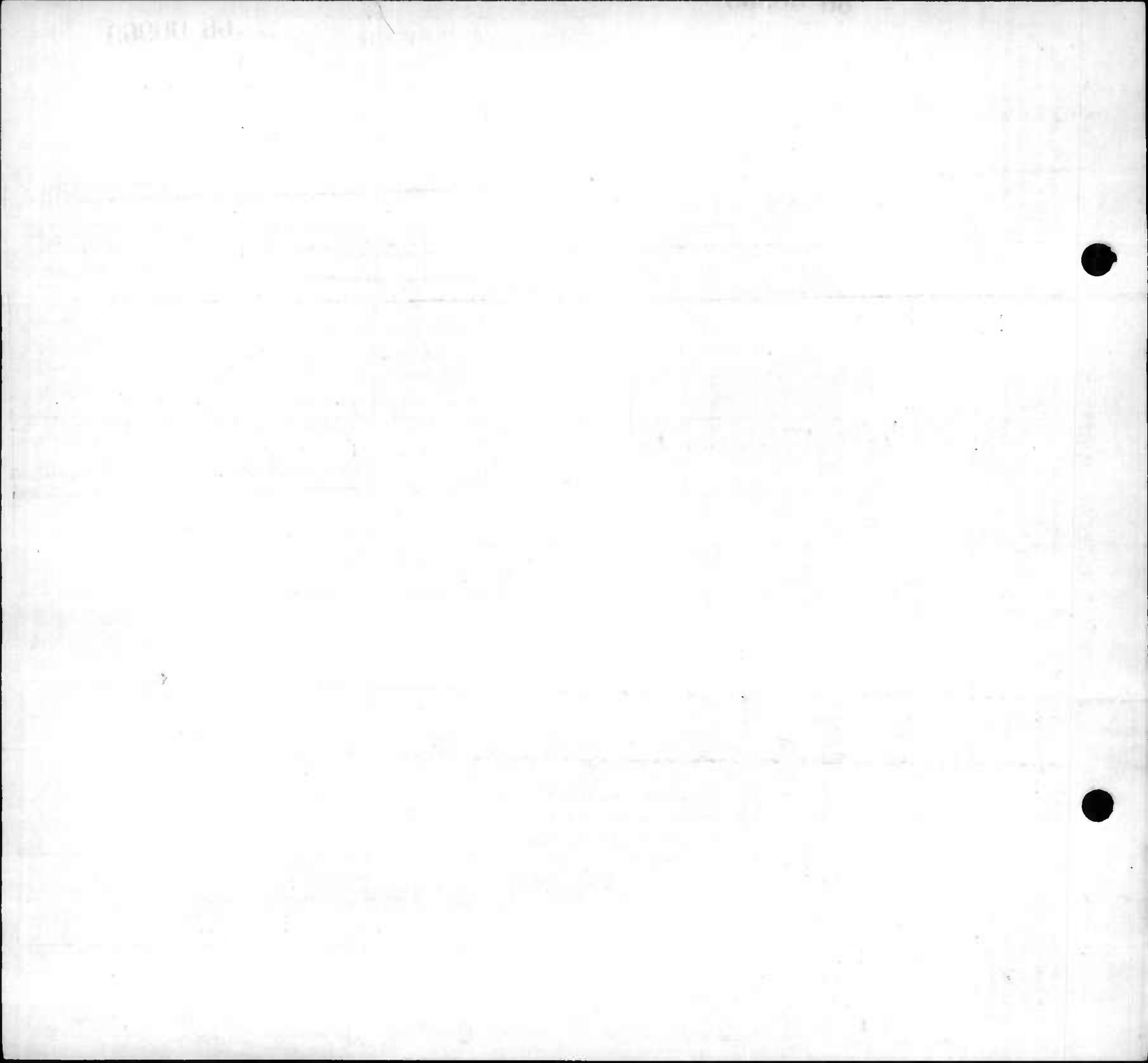
66 00968		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00968	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) SCHENKEL MR. WILBUR O.			2. DATE AND HOUR OF DEATH 1-26-66		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO. CO.		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BON SECOURS HOSPITAL			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21228 5300		
			D. STREET ADDRESS (If rural, give location) 200 PRESTON COURT		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 6-11-1904	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) ASS'T AGENT FRUIT CANNERS EXPRESS RAILWAY		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD	
13. FATHER'S NAME SAMUEL SCHENKEL			14. MOTHER'S MAIDEN NAME LYDIA WRIGHTLER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS HOSPITAL RECORDS	
18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) INTERLATIC Brain Tumor. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Ca of Lung.			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-2-25 1965 to 1-26 1966 , that (I) (we) last saw the deceased alive on 1-26 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Accinelli				23B. DATE SIGNED 1-26-66	
23C. PHYSICIAN'S NAME (Type) JAIME ACCINELLI				23D. ADDRESS Bon Secours Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1/29/66		24C. NAME OF CEMETERY or CREMATORY LOUDBON PARK	
		24D. LOCATION (City, town, or county) (State) BALTO. MD.			
25A. DATE REC'D BY HEALTH DEPT. FEB 1 1966		25B. NAME OF REGISTRAR Col. E. J. ...		25C. FUNERAL DIRECTOR ADDRESS 505 MACNABER 301 FREDERICK RD 21228	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 66 00969	
BIRTH NO. 66-00969		M.E. CASE NO. 66-00969		1. NAME OF DECEASED (Type or Print) Jane Frances Early		2. DATE AND HOUR OF DEATH 1/26/66 3:55 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 1206 W. Lombard St. Baltimore 23, Md.				A. STATE Maryland B. COUNTY 18-03			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 1206 W. Lombard St.			
5. SEX F	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Aug 26, 1889	9. AGE (In years lost birthday) 76	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sec.		10B. KIND OF BUSINESS OR INDUSTRY M.J. Frederick		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas V. Early				14. MOTHER'S MAIDEN NAME Lucinda Jane Daiger			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Miss Marie G. Cox, 1206 W. Lombard St.			
18. 434.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pulmonary edema				CAUSE OF DEATH (A) DUE TO Melnection		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cor. Pulmonale				(B) DUE TO		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1965 to 1-26 19 66 , that (I) (we) lost saw the deceased alive on 1-26 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Stanley Ankudas M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1-28-66	
23C. PHYSICIAN'S NAME (Type) Dr. Stanley Ankudas				23D. ADDRESS M.D. 1802 W. Baltimore St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. FEB 1 1966		25B. NAME OF REGISTRAR Clara S. Taylor		25C. FUNERAL DIRECTOR Cole Funeral Home		ADDRESS 1915 W. Balto. St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00970	
BIRTH NO. 66 00970		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GEORGE N. BROWN		2. DATE AND HOUR OF DEATH Jan 26, 1966	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND 4423 Old York Road		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-10			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 4423 Old York Road			
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Dec. 24, 1878	9. AGE (In years lost birthday) 87	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labored		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Samuel Brown		14. MOTHER'S MAIDEN NAME Rachel Moore			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Vertelle Hall 4423 Old York Rd.	
18. 4 20.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) uremia DUE TO (B) Arteriosclerosis Hard Heart DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 1 1/2	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-23-1965 to 1-26-1966 that (I) (we) lost saw the deceased alive on 1-26-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>G. Franklin Phillips</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1/27/66	
23C. PHYSICIAN'S NAME (Type) G. Franklin Phillips		23D. ADDRESS 558 Mc Modan St. Balt. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-28-66		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park	
		24D. LOCATION (City, town, or county) (State) Arbutus. Balto. Co., Md.			
25A. DATE REC'D BY HEALTH DEPT. FEB 1 1966		25B. NAME OF REGISTRAR <i>Cliff E. Feltner</i>		25C. FUNERAL DIRECTOR (Mrs) Frances A. Hemsley	
				ADDRESS 578 W. Biddle St.	

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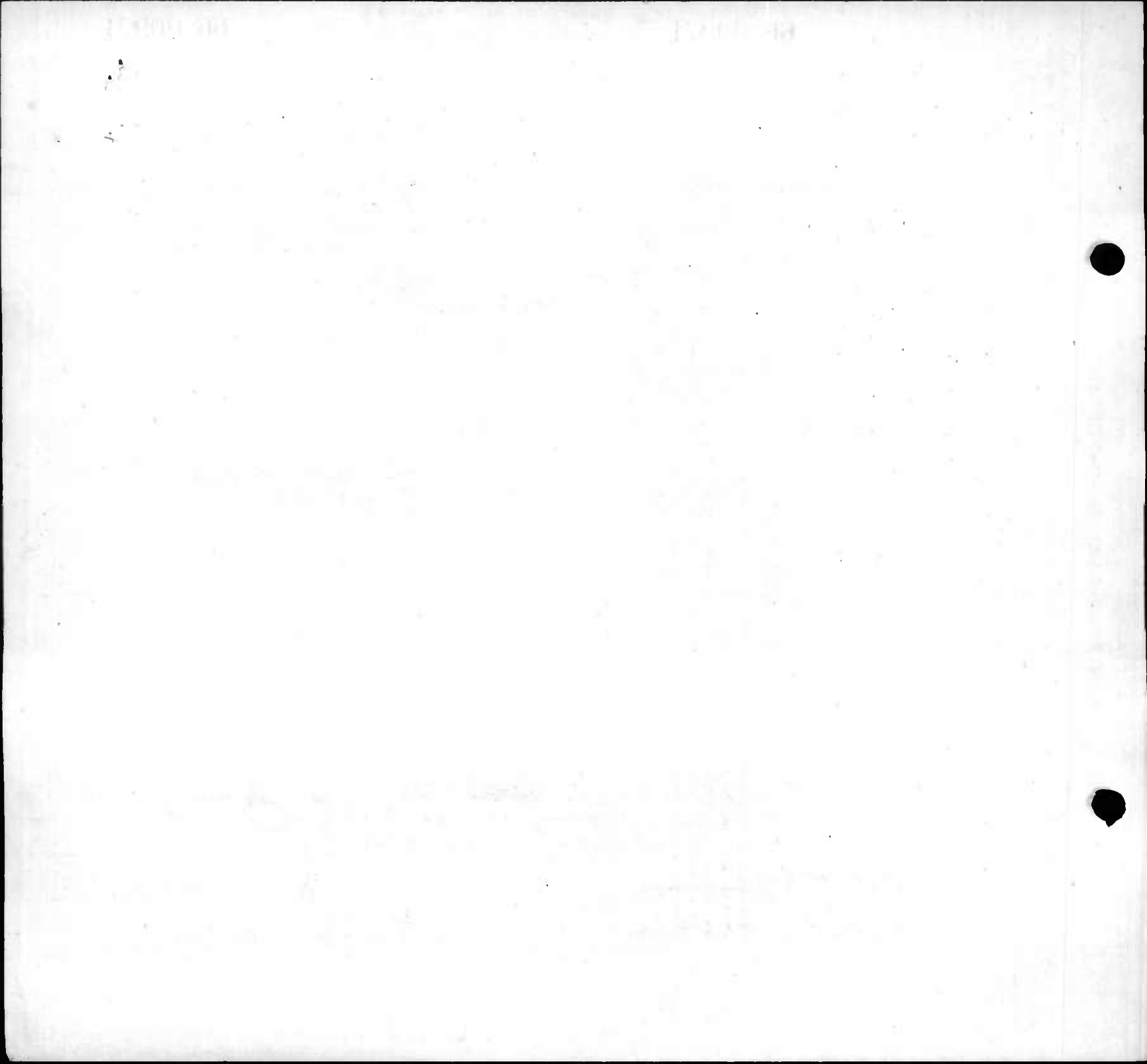
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>66 00971</u>	
66 00971				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Helen Gray Johnson</u>	
2. DATE AND HOUR OF DEATH <u>1/27/66</u>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>46 Lutheran Hospital</u>			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>15-03</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>1521 N. BENTALOU ST</u>			
5. SEX <u>Fe</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>60</u>	9. AGE (In years last birthday) <u>60</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>TRENTON S.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>LEONA SPRIGGS 1823 RUTLAND AVE</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <u>378X</u>		CAUSE OF DEATH (A) <u>Unknown</u> (B) <u>Diverticulitis??</u> (C) <u>ruptured diverticula??</u> <u>ca of Colon??</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 days??</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Electrolyte Imbalance</u> <u>Dehydration</u>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>January 24</u> 19 <u>66</u> to <u>January 27</u> 19 <u>66</u> , that (I) (we) lost saw the deceased alive on <u>January 27</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert C. Blackman</u>				23B. DATE SIGNED <u>1/27/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>Robert C. Blackman</u>				23D. ADDRESS <u>Lutheran Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24B. DATE <u>1/29/66</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mount Zion Church</u>	
24D. LOCATION (City, town, or county) (State) <u>Trenton S.C.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>FEB 1 1966</u>			
25B. NAME OF REGISTRAR <u>Chas E. Taylor</u>		25C. FUNERAL DIRECTOR <u>2000 1/2 S. Long St</u>			



BIRTH NO.

66 00972

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)M.
Albert Leimkuhler

2. DATE AND HOUR PRONOUNCED DEAD

1/28/66

4:55 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

27-01

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2870 Pelham Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married

8. DATE OF BIRTH

9/18/1898

9. AGE (In years
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

ret-Treasurer

10B. KIND OF BUSINESS OR INDUSTRY

Arundel Corp.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Ferdinand Leimkuhler

14. MOTHER'S MAIDEN NAME

Margaret Heine

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

212-01-5046

17. INFORMANT

ADDRESS

Marguerite Hauf Leimkuhler, wife, above

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A).....
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B).....
DUE TO

(C).....

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/28/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2/1/66

23C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

FEB 1 1966

24B. NAME OF REGISTRAR

Albert E. Fink

24C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.

ADDRESS

3331 Brehms Lane

66 00973

66 00973

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)H.
GRAHAM LAWRENCE

2. DATE AND HOUR PRONOUNCED DEAD

January 27, 1966 3:30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1610 Shakespeare St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

2-03

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1610 Shakespeare St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
separated

8. DATE OF BIRTH

12/10/1900

9. AGE (In years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Painter

10B. KIND OF BUSINESS OR INDUSTRY

Board of Education

11. BIRTHPLACE (State or foreign country)

Portsmouth, Va.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Frank Lawrence

14. MOTHER'S MAIDEN NAME

Pocahontas ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

1919-1920

16. SOCIAL
SECURITY NO.

215-10-9558

17. INFORMANT

ADDRESS
4055 St. Augustine Lane, 22
Donald Lawrence, son

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Chronic lung disease
DUE TO fibrocaceous tuberculosis (by history)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S NAME (Type)
Rudiger Breitenecker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-27-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1/31/66

23C. NAME OF CEMETERY or CREMATORY

Balto. Nat. Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

FEB 1 1966

24B. NAME OF REGISTRAR

Robert E. Johnson

24C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.
2601 E. Madison St.

ADDRESS

BB 00073

BB 00073

1919-1920

Board of Education

Portsmouth, N.H.

Postmaster

Printed and Published

1919-1920

Portsmouth, N.H.

WALTER D. BROWN

WALTER D. BROWN

Portsmouth, N.H.

Printed and Published

1919-1920

Portsmouth, N.H.

Printed and Published

1919-1920

66 00974

BALTIMORE CITY HEALTH DEPARTMENT

66 00974

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EARL A. PIPER

2. DATE AND HOUR PRONOUNCED DEAD

1-29-66 1220 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BALTO City Hosp (D&A)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

26-36

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6767 Graceland Avenue

5. SEX

MALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Oct-20-1917

9. AGE (In years
last birthday)

48

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Conductor

10B. KIND OF BUSINESS OR INDUSTRY

Penn.RR

11. BIRTHPLACE (State or foreign country)

Duncansville Pa.

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Arthur A. Piper

14. MOTHER'S MAIDEN NAME

Ora Helsel

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

WWII

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Minnie Piper 6767 Graceland Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Rupture of Aorta -
Idiopathic Medial Necrosis

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

R. S. FISHER

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐EXAMINER'S
NAME (Type)

R. S. FISHER

1/30/66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2-2-66

23C. NAME OF CEMETERY or CREMATORY

Oaklawn Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

FEB 1 1966

O. G. T. Fisher

Walter Dobrowski 1005 Dundalk Ave.

THE NEW YORK PUBLIC LIBRARY

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500 N. 5TH ST. NEW YORK, N. Y. 10017

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 66 00975	
BIRTH NO. 66 00975 341										CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Miller, Milton</i>					2. DATE AND HOUR OF DEATH <i>1-26-66</i> <i>1:40 P.M.</i>						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Sinai Hospital</i>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>28-31</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>4115 New Bern Ave</i>						
5. SEX <i>Male</i>		6. RACE <i>White</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>		8. DATE OF BIRTH <i>1-26-66</i>		9. AGE (In years last birthday) <i>47</i>		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MERCHANT MARINE</i>					10B. KIND OF BUSINESS OR INDUSTRY <i>SHIPPING</i>		11. BIRTHPLACE (State or foreign country) <i>BALTIMORE, MARYLAND</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>JACOB MILLER</i>					14. MOTHER'S MAIDEN NAME <i>LENA ENTEN</i>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>YES WW 2 ARMY</i>					16. SOCIAL SECURITY NO.		17. INFORMANT <i>MRS. FANNIE MILLER</i> ADDRESS <i>4115 NEWBERN AVENUE</i>				
18. <i>294X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>G-I bleed</i> CAUSE OF DEATH (A) DUE TO <i>Polycythemia vera</i> (B) DUE TO (C) DUE TO										INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <i>2</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that <i>(at)</i> this hospital attended the deceased from <i>1/21/66</i> 19 <i>66</i> to <i>1/26</i> 19 <i>66</i> , that (I) <i>(last)</i> saw the deceased alive on <i>1/26</i> 19 <i>66</i> and that in (my) <i>(last)</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>(did)</i> (did not) view the body after death.											
23A. SIGNATURE <i>Leonard J. Hertzberg</i> M.D.										23B. DATE SIGNED <i>1-26-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>Leonard J. Hertzberg</i> M.D.					23D. ADDRESS <i>Sinai Hosp Baltimore, MD</i>						
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>			24B. DATE <i>1/27/66</i>		24C. NAME OF CEMETERY OR CREMATORY <i>TIFEREH ISRAEL ANSHE SFARD</i>			24D. LOCATION (City, town, or county) (State) <i>ROSEDALE, MARYLAND</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>FEB 1 1966</i>					25B. NAME OF REGISTRAR <i>Cliff E. Taylor</i>		25C. FUNERAL DIRECTOR <i>SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD</i>				

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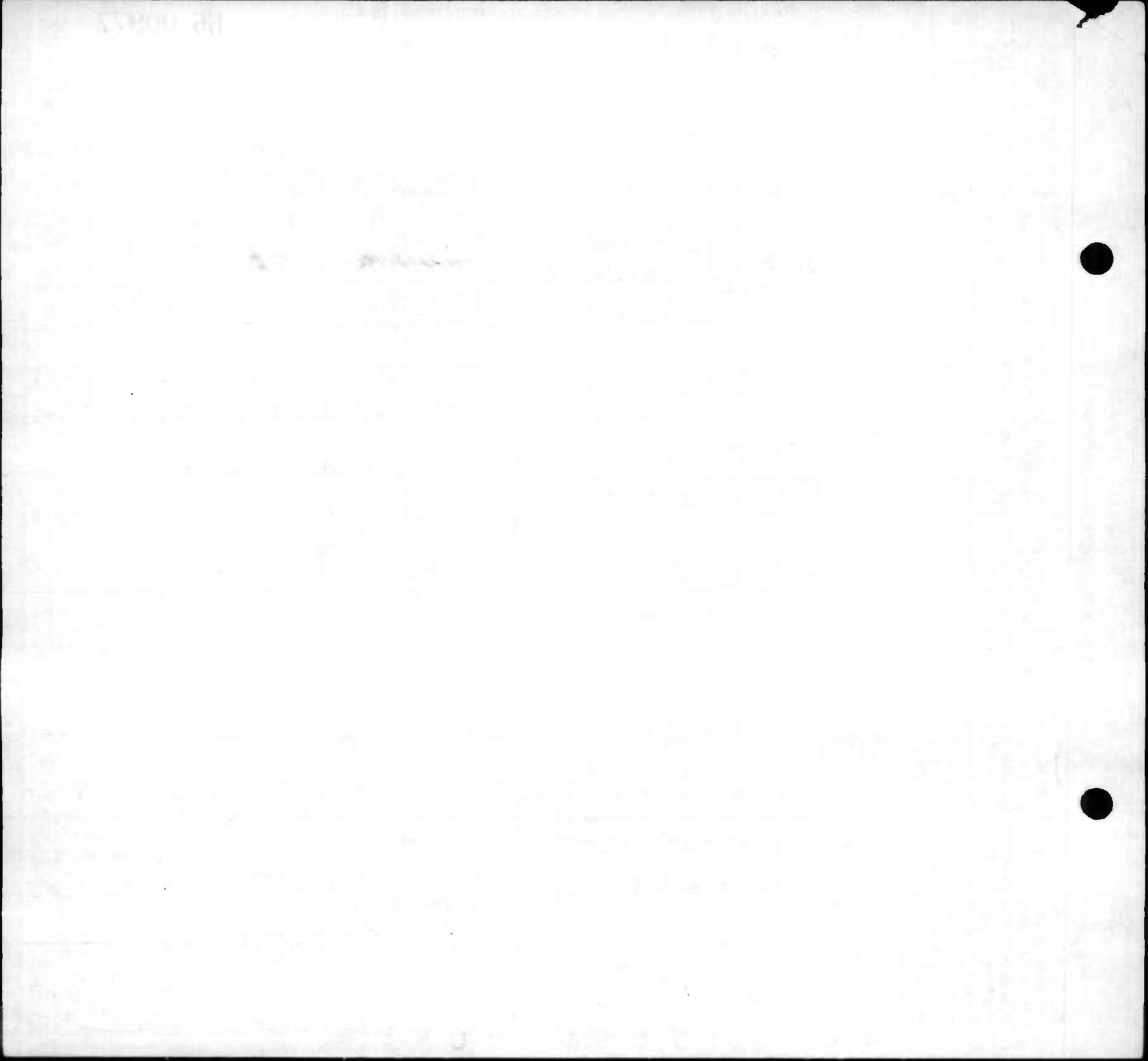
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

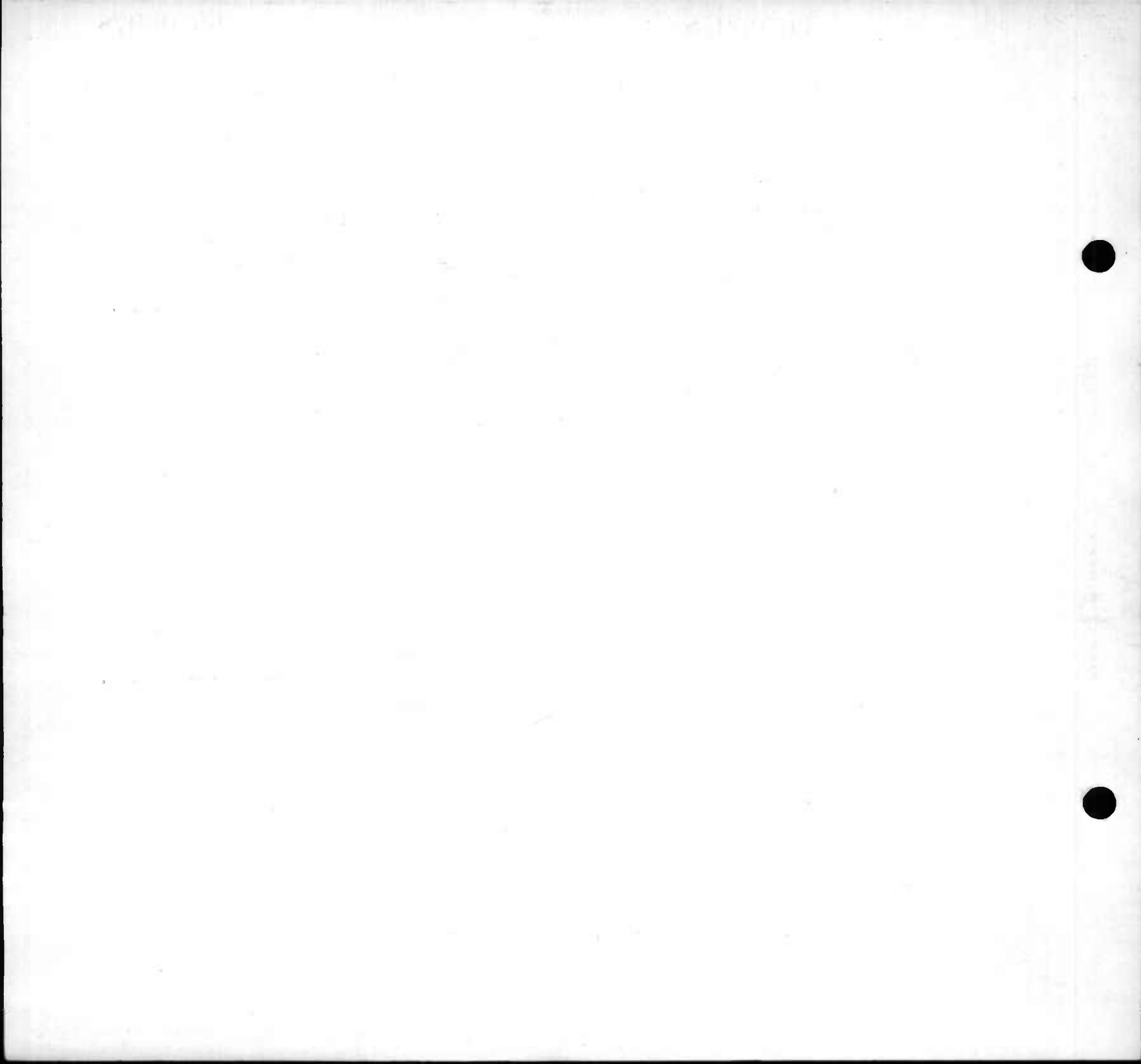
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>66 00977</u>	
BIRTH NO. <u>66 00977</u>							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <u>SIMON APPLEBAUM</u>				2. DATE AND HOUR OF DEATH <u>JANUARY 24, 1966 11:40 P.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL OF BALTIMORE</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>MARYLAND</u>		B. COUNTY <u>27-18</u>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
				D. STREET ADDRESS (If rural, give location) <u>3617 WEST GARRISON AVE.</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>4/10/1892</u>	9. AGE (In years last birthday) <u>73</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAILOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>SHOP</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-32-2962</u>		17. INFORMANT <u>MRS. Rebecca Applebaum</u> <u>3617 W. GARRISON AVE</u>			
18. <u>722.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>CEREBROVASCULAR ACCIDENT</u> DUE TO (B) <u>ASCVD</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 MONTHS</u> <u>3 YEARS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>JANUARY 20</u> 19 <u>66</u> to <u>JANUARY 24</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>JANUARY 24</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Herbert Fellerman</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>Jan 24, 1966</u>	
23C. PHYSICIAN'S NAME (Type) <u>HERBERT FELLERMAN</u>				23D. ADDRESS <u>SINAI HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/26/66</u>		24C. NAME of CEMETERY or CREMATORY <u>Moses Montefiore Hebrew</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 1 1966</u>		25B. NAME OF REGISTRAR <u>Robert E. Fellerman</u>		25C. FUNERAL DIRECTOR <u>Ed Levine & Sons Inc</u> <u>6010 Rust Rd</u>			



Registered No.

M.

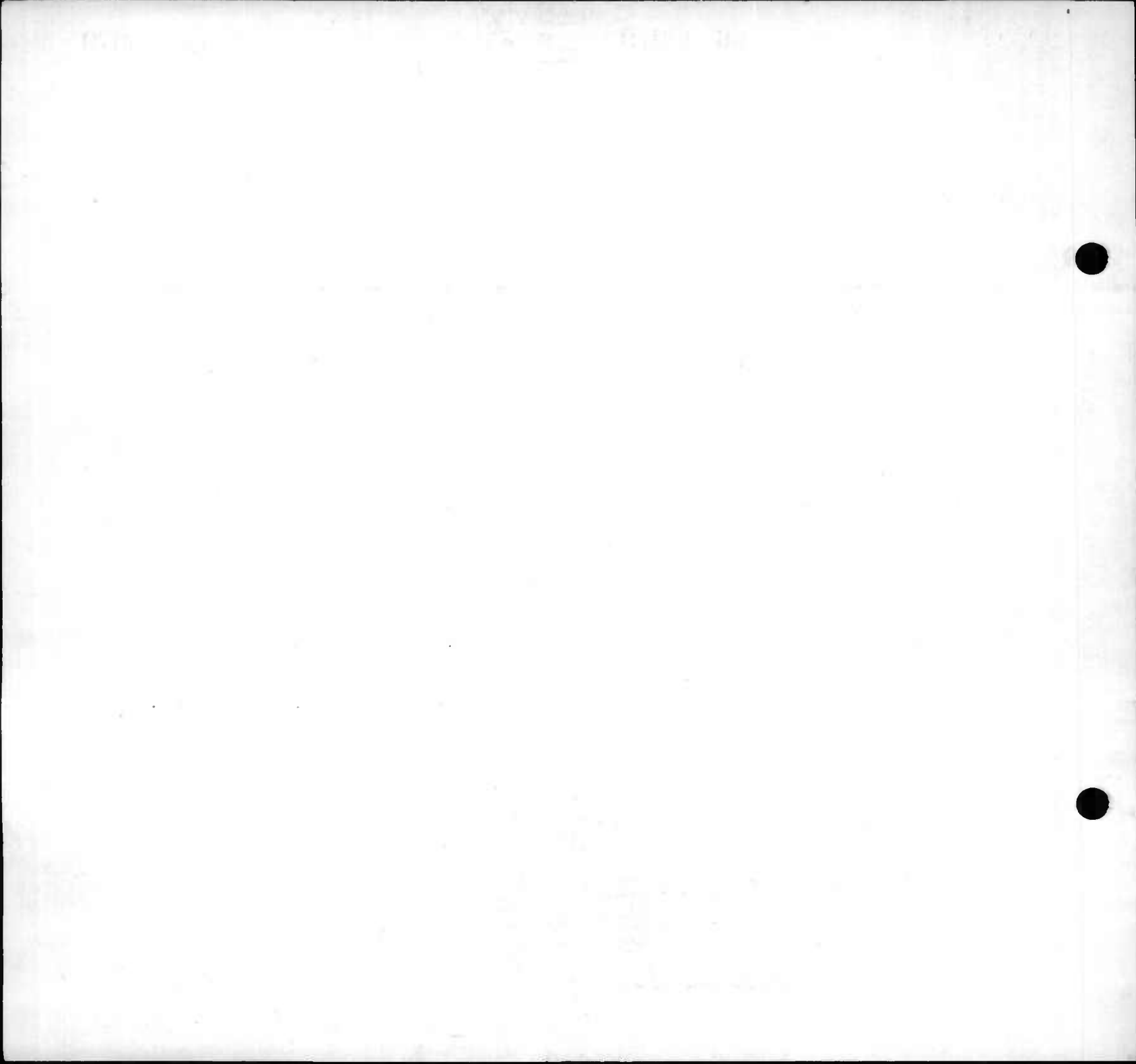
VS 150-REV. 1/1765



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00979	
BIRTH NO. 66 00979		CERTIFICATE OF DEATH		Registered No. 66 00979	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ORVILLE MALONE HILL			
2. DATE AND HOUR OF DEATH January 19, 1966 6:30 A.M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital			
4. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission) A. STATE Maryland B. COUNTY Pr. George C. CITY OR TOWN (If outside city limits, write RURAL and give township) Rural - Laurel 66-00 D. STREET ADDRESS (If rural, give location) 212 10th St.		5. SEX M 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) never married 8. DATE OF BIRTH 4/9/48 9. AGE (In years last birthday) 17			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Tennessee	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Isaac Hill			
14. MOTHER'S MAIDEN NAME Lellie McKenig		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO.		17. INFORMANT Medical Records ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 3-39, 14-260X		CAUSE OF DEATH (A) Medicament DUE TO (B) Ruptured exophagus DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Ketoacidosis			
19A. DATE OF OPERATION 3/1/76		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Pneumothorax		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 16 19 66 to Jan 19 19 66 , that (I) (we) last saw the deceased alive on Jan 19 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Barry N. Rosenbaum M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/19/66	
23C. PHYSICIAN'S NAME (Type) BARRY N. ROSENBAUM M.D.		23D. ADDRESS UNIVERSITY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-22-66		24C. NAME OF CEMETERY OR CREMATORY Sanage Cemetery	
24D. LOCATION (City, town, or county) Sanage, Maryland		(State) MD			
25A. DATE REC'D BY HEALTH DEPT. FEB 1 1966		25B. NAME OF REGISTRAR Cliff E. Taylor		25C. FUNERAL DIRECTOR Robert Hamilton ADDRESS Laurel, Md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		66 00980		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 66 00980	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				Adams, Dorothy A.		1/24/66		12:55 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				Md. Howard.		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
Univ. Hosp. Balt., Md.				D. STREET ADDRESS (If rural, give location)		Laurel		6300	
375 N. Second St.				5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
F				White		Married			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife				None		Md.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Charles S. Souder				Esther Sauder		No		-	
17. INFORMANT				ADDRESS		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
George O. Adams				Laurel Md.		Cardiac Arrest		30 min	
						(A) DUE TO			
						(B) DUE TO		Shock-Vascular Collapse 3 days	
						(C) DUE TO		Recurrent Sq. Cell Ca. Cervix Years	
19. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				Recurrent Ca. Cvx.		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
No									
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
				White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>					
22. I certify that (this hospital) attended the deceased from				1/24/1966		1965 to		1/24/1966	
that (I) (we) last saw the deceased alive on				1/24/1966		and that in (our) opinion death occurred on the date			
and hour and from the causes stated above. (We) (did) (did not) view the body after death.									
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED		1/24/66	
Jerry L. Cates									
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Jerry L. Cates				6024 Loch Raven Blvd. Balt., Md.		Burial		1-26-66	
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
Fort Lincoln Cem				Colman Manor Md		FEB 1 1966		D. A. 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100	
25C. FUNERAL DIRECTOR				ADDRESS		25D. NAME OF REGISTRAR		25E. FUNERAL DIRECTOR	
Dewitt Donaldson				Laurel Md					

54

24

Dec 24 - 1st Rayon Drive
Dec 11 - 12, 14

18000-80

VALLEY FOLIO

18000-80

18000-80

18000-80

BIRTH NO. *61-01216* MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

M.E. CASE NO. _____

1. NAME OF DECEASED (Type or Print) **SANDI RILEY** 2. DATE AND HOUR PRONOUNCED DEAD **1-24-66 10:15 A.M.**3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE **Maryland** B. COUNTY **13-02**

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

926 NEWINGTON AVENUE

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

926 Newington Avenue 212175. SEX **Female** 6. RACE **Colored** 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) 8. DATE OF BIRTH **Jan. 16/61** 9. AGE (In years last birthday) **5** 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 11. BIRTHPLACE (State or foreign country) **Baltimore, Md.** 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

James Taylor

14. MOTHER'S MAIDEN NAME

Gertrude Riley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Minnie Smith 913 Durham St

ADDRESS

18. **E 9821** CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) **Multiple stab wounds of neck**
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO(C)
DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) **Yes** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? **Yes**

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) **Home**21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) **3rd floor rear bedroom**21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) **12 '66 ? m.**

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Throat cut22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE

Russell S. Fisher

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-24-6623A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 23B. DATE **Feb 3/66** 23C. NAME OF CEMETERY or CREMATORY **Westport Cem.** 23D. LOCATION (City, town, or county) (State) **Westport Md**24A. DATE REC'D BY HEALTH DEPT. **FEB 1 1966** 24B. NAME OF REGISTRAR **Robert E. Fisher** 24C. FUNERAL DIRECTOR **Milton E. Eckman** ADDRESS **1129 N. Carroll**

BIRTH NO.

M.E. CASE NO.

63-10271 66 00983 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 66 00983

1. NAME OF DECEASED
(Type or Print)

JACQUELINE TAYLOR

2. DATE AND HOUR PRONOUNCED DEAD

1-24-66

10:14 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

926 NEWINGTON AVENUE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

926 Newington Avenue 21217

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

April 3 1962

9. AGE (In years
last birthday)

3

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

James Taylor

14. MOTHER'S MAIDEN NAME

Serrine Riley

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Minnie Smith 913 Durham St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Multiple stab wounds of neck
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR? 3rd floor rear bedroom

926 Newington Avenue

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

12

'66 ?

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Stabbed

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

1-24-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Feb 3/66

23C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cem

23D. LOCATION

(City, town, or county)

Westport Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

FEB 1 1966

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Milton E. Elchman 1129 N. Carroll St

ADDRESS

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UNITED STATES DEPARTMENT OF AGRICULTURE

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BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

66 00984

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

66 00984

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

GERVINE TAYLOR

2. DATE AND HOUR PRONOUNCED DEAD

1-24-66 10:10 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

926 NEWINGTON AVENUE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

926 Newington Avenue 21217

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

Aug. 20/42

9. AGE (In years last birthday)

23

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Manning S.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Henry Riley

14. MOTHER'S MAIDEN NAME

Minnie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Minnie Smith 9137 Durham

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) Subdural hematoma with multiple contusions of the brain and stab wound of the neck

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

3rd floor front bedroom

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

1

?

'66

?

m.

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Beaten and stabbed

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-24-66

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

Feb 3/66

23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

23D. LOCATION

(City, town, or county)

(State)

Westport Md.

24A. DATE REC'D BY HEALTH DEPT.

FEB 1 1966

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Milton E. Elchman

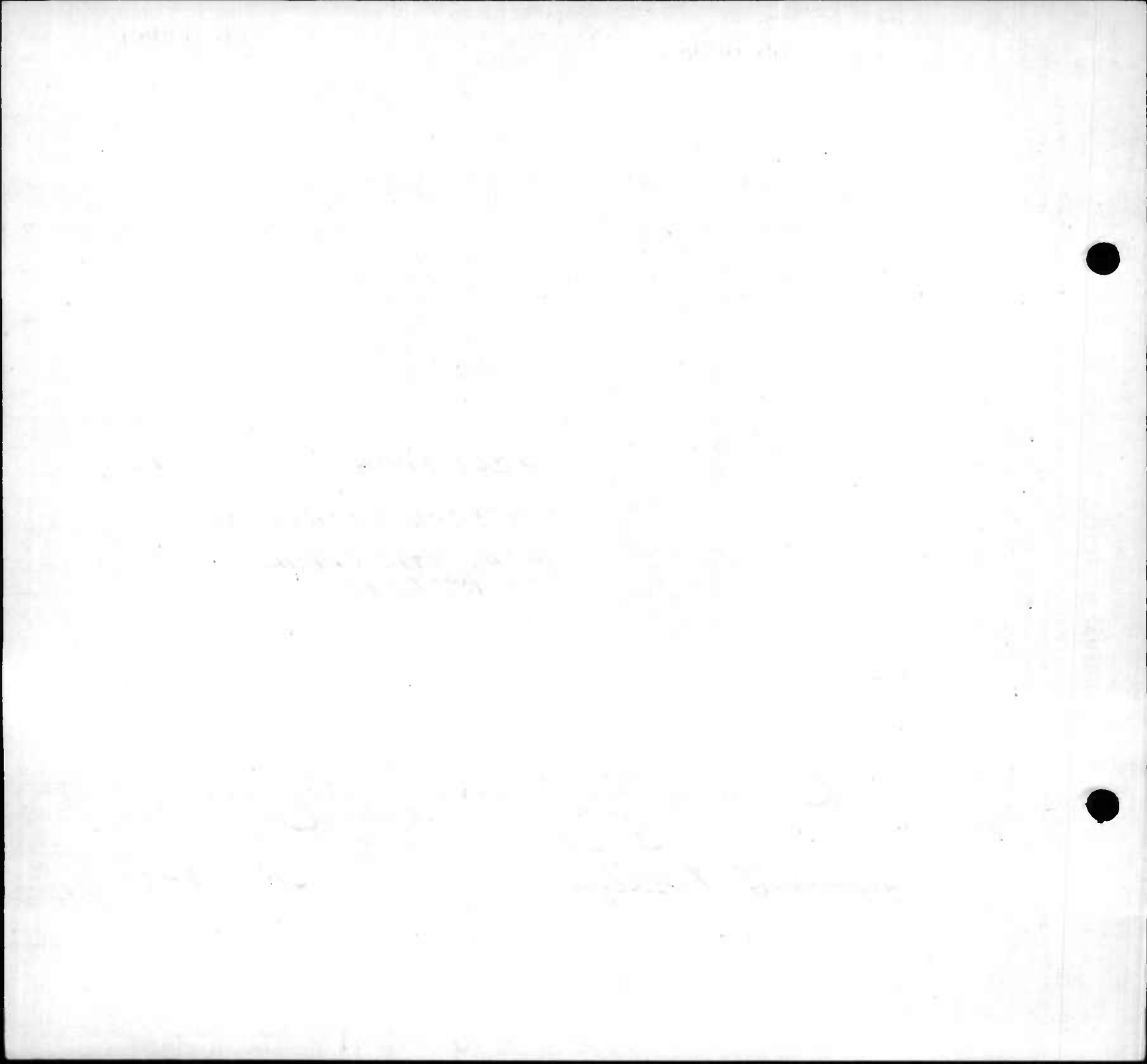
ADDRESS

11297 Laurel

FUNERAL DIRECTOR: IMPORTANT

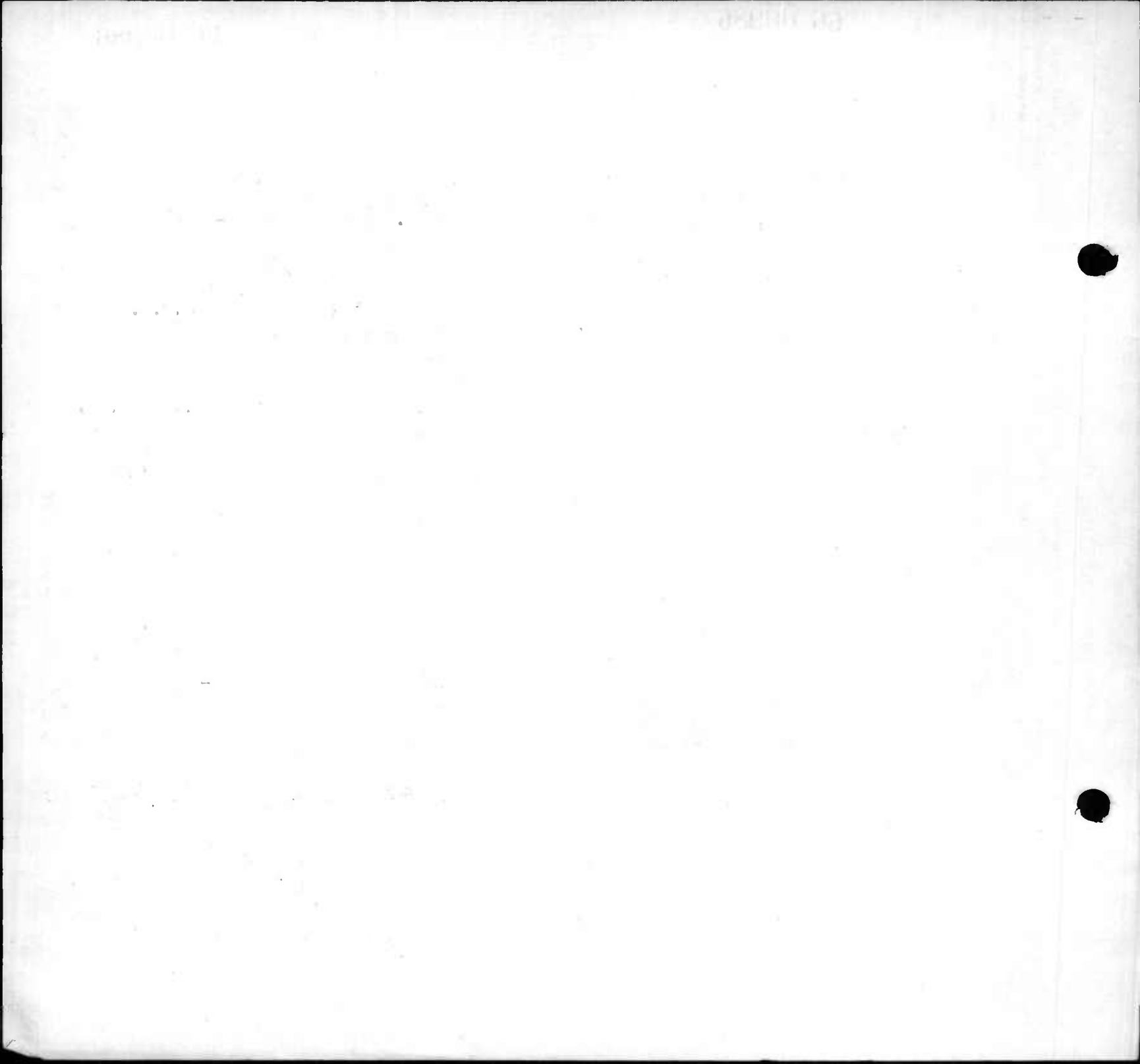
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
Certificate of Death										Registered	
66 00985											
BIRTH NO.											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) <i>Celestine Church</i>						2. DATE AND HOUR OF DEATH <i>1-30-66 11:35 P.M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <i>THE JOHNS HOPKINS HOSPITAL</i>						A. STATE <i>MARYLAND</i>					
(If not in hospital or institution, give street address or location)						B. COUNTY					
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>					
						D. STREET ADDRESS (If rural, give location) <i>1305 DRUID HILL AVENUE</i>					
5. SEX <i>FEMALE</i>	6. RACE <i>NEGRO</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>WIDOWED</i>		8. DATE OF BIRTH <i>5-19-94</i>	9. AGE (In years last birthday) <i>71</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <i>md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>WILLIAM GREEN</i>						14. MOTHER'S MAIDEN NAME <i>ELIZABETH HILL</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Rebards</i>		ADDRESS			
18. <i>154X I</i>											
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)						CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
						(A) <i>AZOTEMIA</i>			<i>6 DAYS</i>		
						(B) <i>URETERAL OBSTRUCTION</i>			<i>9 DAYS</i>		
						(C) <i>METASTATIC CARCINOMA OF RECTUM</i>			<i>60 DAYS +</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <i>12-4-65</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>CARCINOMA OF RECTUM</i>				20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
				White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>							
22. I certify that (1) (this hospital) attended the deceased from <i>1-24</i> 19 <i>66</i> to <i>1-30</i> 19 <i>66</i> , that (1) (we) last saw the deceased alive on <i>1-30</i> 19 <i>66</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>James L. Phillips</i>								M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>1-30-66</i>	
23C. PHYSICIAN'S NAME (Type) <i>JAMES L. PHILLIPS</i>						23D. ADDRESS <i>THE JOHNS HOPKINS HOSPITAL</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Feb. 4/66</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cem.</i>				24D. LOCATION (City, town, or county) (State) <i>Bald Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>FEB 1 1966</i>				25B. NAME OF REGISTRAR <i>Robert E. Carney</i>				25C. FUNERAL DIRECTOR <i>Joseph J. Elchman 11297 Curtis St</i>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 00986		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00986	
BIRTH NO.		M.E. CASE NO. 61-326		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Bertha Whitaker		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 8-07	
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		5. SEX F		6. RACE Negro	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 11-3-89		9. AGE (In years last birthday) 76	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Annannias Edmonds		14. MOTHER'S MAIDEN NAME Susan	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Records: BCH 4940 Eastern Ave., Balto. Md. 21224	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) CVA Hypertension		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 4 mos 8 yrs	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 8 1966 to Jan 30 1966, that (I) (we) last saw the deceased alive on Jan 30 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Alex Silverman		23B. DATE SIGNED 1-30-66	
23C. PHYSICIAN'S NAME (Type) ALEX SILVERMAN		23D. ADDRESS c/o Baltimore City Hospitals Baltimore Maryland 21224		23E. FUNERAL DIRECTOR T. E. Elickson	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 7/3/66		24C. NAME OF CEMETERY or CREMATORY Enfield N. Carolina	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. FEB 1 1966		25B. NAME OF REGISTRAR T. E. Elickson	
25C. FUNERAL DIRECTOR T. E. Elickson		25D. ADDRESS 129 N. Carolina St		25E. ADDRESS	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

(Arle) ARLEIGH INGRAM

2. DATE AND HOUR PRONOUNCED DEAD

January 25, 1966

12:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1035 Homewood Ave.

5. SEX

male

6. RACE

negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

widowed

8. DATE OF BIRTH

April 9, 1900

9. AGE (In years last birthday)

65

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Alice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Benjamin Ingram 1121 N. Caroline St

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Intra-cerebral hemorrhage DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH?

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Rudiger Breiteneker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-26-66

23A. BURIAL CREMATION, REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

FEB 1 1966

VALLEY FOLIO

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90. The Past

91. The Future

92. The Present

93. The Past

94. The Future

95. The Present

96. The Past

97. The Future

98. The Present

99. The Past

100. The Future

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00988	
BIRTH NO. 66 00988		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) IRA TOSSIE		2. DATE AND HOUR OF DEATH 1-28-66 4:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Mersey Hospital		A. STATE MD. B. COUNTY 10-01			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, MD.			
		D. STREET ADDRESS (If rural, give location) 617 E. Biddle St			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 6/6/09	9. AGE (In years last birthday) 56	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pa.	
13. FATHER'S NAME H. B.		14. MOTHER'S MAIDEN NAME Ella		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Lorris E. Tossie	
				ADDRESS	
18. 420.1 & 260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Intracranial hemorrhage DUE TO and (B) acute myocardial infarction DUE TO (C) HAS UD		INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days 10 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Diabetes Mellitus		5 years	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 1/26 19 66 to 1/28 19 66 , that (we) last saw the deceased alive on 1/28 19 66 and that in our (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) view the body after death.					
23A. SIGNATURE Susan Logst		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/28/66	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 2/4/66		24C. NAME OF CEMETERY or CREMATORY Sanford Florida	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. FEB 1 1966			
25B. NAME OF REGISTRAR John E. Johnson		25C. FUNERAL DIRECTOR ADDRESS 1129 N. Caroline St			

Handwritten text, possibly a title or header, appearing upside down.

Handwritten text, possibly a date or identifier.

Handwritten text, possibly a name or signature.

Handwritten text, possibly a small note or mark.

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Handwritten text, possibly a name or signature.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00989				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00989	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>John Leonard Haugh</u>				2. DATE AND HOUR OF DEATH <u>January 26, 1966 11:45 A.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hosp</u>				A. STATE <u>Maryland</u> B. COUNTY <u>13-07</u>			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>1113 W 42nd Street</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1/1/1907</u>	9. AGE (In years last birthday) <u>59</u>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>EASTERN PRODUCTS</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>
13. FATHER'S NAME <u>Leonard Lynn Haugh</u>			14. MOTHER'S MAIDEN NAME <u>Edith Cook</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or at unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>173-03-1191</u>		17. INFORMANT <u>Wife - Edith Haugh</u>		
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>Acute myocardial infarction</u> DUE TO (B) <u>Coronary atherosclerosis</u> DUE TO (C) <u>Pulmonary edema, severe</u> <u>put</u>			INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1/26/66</u> 19 <u>66</u> to <u>1/26/66</u> 19 <u>66</u> , that (I) (we) lost saw the deceased alive on <u>1/26/66</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Donald D. Hall</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1/27/66</u>	
23C. PHYSICIAN'S NAME (Type) <u>DONALD G. HALL</u>				23D. ADDRESS M.D. <u>UNION MEMORIAL HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/29/66</u>		24C. NAME OF CEMETERY or CREMATORY <u>Lorraine Park.</u>		24D. LOCATION (City, town, or county) (State) <u>Windsor Mill Rd, Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>FEB 1 1966</u>		25B. NAME OF REGISTRAR <u>C. J. E. E. E.</u>		25C. FUNERAL DIRECTOR <u>August E. Honovan</u>			
				ADDRESS <u>3818 Roland Ave</u>			

JAT 7.1. JA 1974 1975

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66 00990

BALTIMORE CITY HEALTH DEPARTMENT

66 00990

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM G. BULL

2. DATE AND HOUR PRONOUNCED DEAD

January 27, 1966

2:37 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)

3542 Milford Mill Rd.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

4/22/1912

9. AGE (In years
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Asst. Train Master

10B. KIND OF BUSINESS OR INDUSTRY

B. & O. R. R.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Herbert Bull

14. MOTHER'S MAIDEN NAME

Ada Dontell

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

705-09-8265

17. INFORMANT

ADDRESS

Evelyn P. Bull-3542 Windsor Mill Rd -21207

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-27-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1/31/66

23C. NAME of CEMETERY or CREMATORY

Woodlawn

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

FEB 1 1966

Loring Byers-8728 Liberty Rd. Randallsta

1/22/1912

1/22/1912

U.S.A.

Baltimore, Md.

P. O. Box 1.

John. T. Smith

Ada House

Herbert Hall

707-00-20000 Foreign P. O. Box 11-35000 Windsor, Ont. - 20007

No

International Convention for the

Baltimore, Md.

Western

1/21/12

1/21/12

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 00991		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00991	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		Brockmeyer, Claudia		JAN 26 1966 11 PM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		A. STATE B. COUNTY	
CERIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSP OF BALTO.		Maryland		Harford	
5. SEX F		6. RACE W		7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 2/14/05	
H W		—		9. AGE (In years last birthday) 60	
13. FATHER'S NAME Benjamin Smith		14. MOTHER'S MAIDEN NAME Betty Tetlow		11. BIRTHPLACE (State or foreign country) Md.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY? USA	
17. INFORMANT Harry M. Walen		ADDRESS 5356 CARRIAGE CT. 21229			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 1. 154X I Metastatic Adenocarcinoma of Rectum		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. unknown		(C) DUE TO			
19A. DATE OF OPERATION 1964		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CANCER RECTUM		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) none		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-17-1966 to 1-26-1966, that (I) (we) lost saw the deceased alive on 1-26-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harry M. Walen				23B. DATE SIGNED 1-26-66	
23C. PHYSICIAN'S NAME (Type) HARRY M. WALLEN		23D. ADDRESS M.D. SINAI HOSP OF BALTO.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/29/66		24C. NAME OF CEMETERY or CREMATORY Belair Mem. Gard.	
24D. LOCATION Harford Co. Md		25A. DATE REC'D BY HEALTH DEPT. FEB 1 1966			
25B. NAME OF REGISTRAR C. C. ...		25C. FUNERAL DIRECTOR Deacon Funeral Home		ADDRESS 7401 Belair Rd. Balto. Md. 21236	

Duplicate Death Cert. from Sinai Hosp.

2-9-66 M.H.

66 00992

BALTIMORE CITY HEALTH DEPARTMENT

66 00992

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES POWLEY

2. DATE AND HOUR PRONOUNCED DEAD

January 26, 1966

9:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

302 Edwards Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Div.

8. DATE OF BIRTH

March 23, 1902

9. AGE (In years
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

W. Va.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Jenny Powley

14. MOTHER'S MAIDEN NAME

Nellie Manley

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

WW I

16. SOCIAL
SECURITY NO.

17. INFORMANT

Family

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-26-66

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

1-29-66

23C. NAME of CEMETERY or CREMATORY

London Pk. Cem

23D. LOCATION

(City, town, or county)

(State)

Walto 29, Md.

24A. DATE REC'D BY HEALTH DEPT.

FEB 1 1966

24B. NAME OF REGISTRAR

C. E. 2, J. J. J.

24C. FUNERAL DIRECTOR

Hedley Funeral Home

ADDRESS

237 Baltimore Ave

SPRING 1910

SPRING 1910

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

RESEARCH REPORT

BY

JOHN EDGAR HOOVER

AND

WILLIAM A. RICHARDS

CHICAGO, ILLINOIS

1910

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

RESEARCH REPORT

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AND

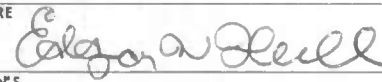
WILLIAM A. RICHARDS

CHICAGO, ILLINOIS

1910

FUNERAL DIRECTOR: IMPORTANT

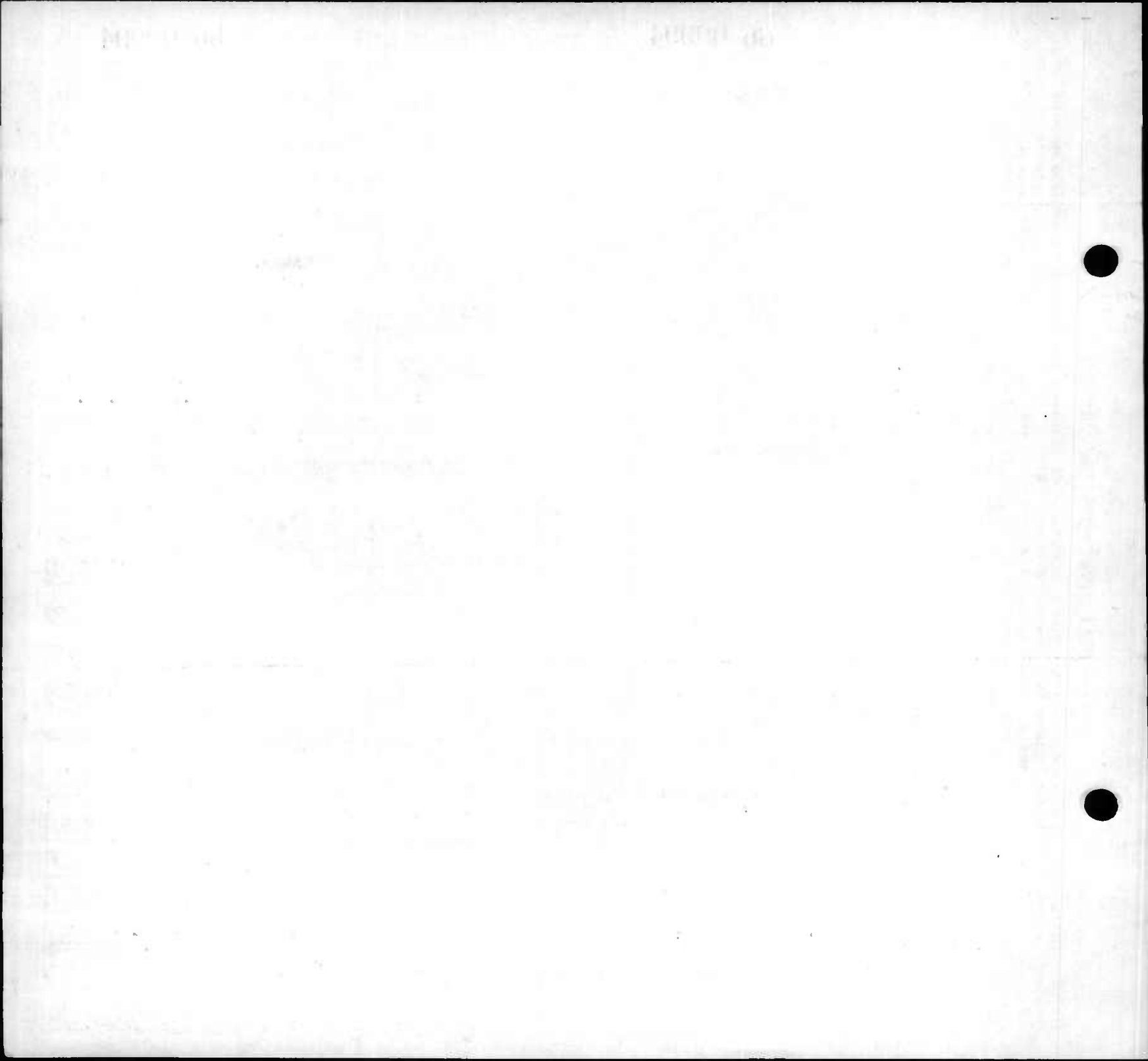
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

66 00993				CITY HEALTH DEPARTMENT		Registered No. 66 00993	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Procenko, Nikon				January 27, 1966 11:25 p M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital				A. STATE Maryland, Baltimore			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 109 N. Montford Ave.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 3-23-92	9. AGE (In years last birthday) 73	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardener-Janitor		10B. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) Ukraine		12. CITIZEN OF WHAT COUNTRY? Ukraine	
13. FATHER'S NAME (Thomas) Foma Procenko				14. MOTHER'S MAIDEN NAME Salomia Kulshauer Morhun			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No -		16. SOCIAL SECURITY NO. 213-30-8872		17. INFORMANT ADDRESS Patient, wife, same address Mrs. Anna Procenko, 109 N. Montford Ave			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				Caridac arrhythmia		10 min.	
				(A) DUE TO			
				(B) ? myocardial infarction		?	
				(C) XXXX ASCVD		years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Pulmonary emphysema.		years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, loim, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from January 22 19 66 to January 27 19 66, that (I) (we) last saw the deceased alive on January 27 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE 				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 1-28-66	
23C. PHYSICIAN'S NAME (Type) Edgar W. Hull				23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/31/66		24C. NAME of CEMETERY or CREMATORY St. Andrew Russian Orth.		24D. LOCATION Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. FEB 1 1966		25B. NAME OF REGISTRAR Edgar W. Hull		25C. FUNERAL DIRECTOR ADDRESS M.F. SADOWSKI & SONS, 1808 EASTERN AVE			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 64-08224		66 00994		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00994	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Terry Hughes</u>		2. DATE AND HOUR OF DEATH <u>1/22/66</u> <u>11 40</u> A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		D. STREET ADDRESS (If rural, give location) <u>310 Homberg Ave Baltimore, Md</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospital</u> <u>4940 Eastern Avenue</u> <u>Baltimore 24, Md</u>		5. SEX <u>Female</u> 6. RACE <u>White</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Never</u> <u>Married</u>		8. DATE OF BIRTH <u>3/26/64</u>		9. AGE (In years lost birthday) <u>ONE</u> <u>15</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>Phyllis Hughes</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>RECORDS: BCH 4940 Eastern Ave., Balto. Md. 21224</u>		ADDRESS		18. <u>519.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory Failure</u> <u>Staphylococcus</u> <u>33 days</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		20. CAUSE OF DEATH <u>Staphylococcus</u> <u>33 days</u> <u>Un-known</u> <u>33x days</u>		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12/25</u> 19 <u>66</u> to <u>1/22</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/33</u> 19 <u>66</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <u>M. Steiner</u>		23B. DATE SIGNED <u>1/22/66</u>			
23C. PHYSICIAN'S NAME (Type) <u>M. Steiner</u>		23D. ADDRESS M.D. <u>4940 Eastern Avenue, Baltimore, Md. 21224</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal Jan 24/66 Ashboroale lum</u>		24B. DATE <u>1/24/66</u>	
24C. NAME OF CEMETERY or CREMATORY <u>N. Va</u>		24D. LOCATION (City, town, or county) (State) <u>N. Va</u>		25A. DATE REC'D BY HEALTH DEPT. <u>FEB 1 1966</u>		25B. NAME OF REGISTRAR <u>Phyllis Herwig</u>	
25C. FUNERAL DIRECTOR <u>Phyllis Herwig</u>		ADDRESS <u>2024 Calverton St</u>		25D. DATE REC'D BY HEALTH DEPT. <u>FEB 1 1966</u>		25E. NAME OF REGISTRAR <u>Phyllis Herwig</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00995		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 66 00995	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Sara Jane Patterson</i>			2. DATE AND HOUR OF DEATH <i>1/26/66 10 P. M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>44 Union Memorial Hospital</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>White Hall, Md. 5300</i> D. STREET ADDRESS (If rural, give location) <i>Peters Avenue</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>4/4/86</i>	9. AGE (In years last birthday) <i>79 yrs.</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Sewing Factory</i>		11. BIRTHPLACE (State or foreign country) <i>West Va., Martinsburg.</i>	
13. FATHER'S NAME <i>Samuel H. Howard</i>			14. MOTHER'S MAIDEN NAME <i>Margaret Cox</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>213-03-6942</i>		17. INFORMANT <i>Mrs. Janice Kneager</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Uremia & Renal Shutdown</i>			CAUSE OF DEATH (A) <i>Acute Myocardial Infarction</i> DUE TO (B) <i>Hypertensive Cardiovascular Disease</i> DUE TO (C) <i>Diabetes mellitus</i>		INTERVAL BETWEEN ONSET AND DEATH <i>years</i>
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <i>(this hospital)</i> attended the deceased from <i>January 25, 1966</i> to <i>January 26, 1966</i> , that <i>(we)</i> last saw the deceased alive on <i>1/26</i> 19 <i>66</i> and that in <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. <i>(We)</i> (did) <i>(did not)</i> view the body after death.					
23A. SIGNATURE <i>A. C. Tipton Jr.</i>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>1/26/66</i>
23C. PHYSICIAN'S NAME (Type) <i>ANCEL C. TIPTON, JR.</i>			23D. ADDRESS <i>23rd & Calveet Sts.</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Jan 28 1966</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Wiseburg Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>White Hall, Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>FEB 1 1966</i>		25B. NAME OF REGISTRAR <i>Robert G. Taylor</i>		25C. FUNERAL DIRECTOR <i>Joseph Hartenstein</i>	
				ADDRESS <i>New Freedom, Pa.</i>	

AL 111

AL 111

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 66 00996		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 66 00996	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Henry Abramovitz		2. DATE AND HOUR OF DEATH 5:50 PM 1/27/66 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-16			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Jewish Convalescent Home		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) Pall Mall Drive - Balt. 4601			
5. SEX M	6. RACE E W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 12/3/1877	9. AGE (In years lost birthday) 88	10. Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Tailor		11. BIRTHPLACE (State or foreign country) Russia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME NECHAE MIL ABROMOVITZ		14. MOTHER'S MAIDEN NAME MARIOSSA ABROMOVITZ	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS NATHAN ABROMOVITZ	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Bronchopneumonia (B) DUE TO Gangrene left Foot (C) DUE TO Arteriosclerotic Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH 12 hours 1 month	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/3/64 19 to 1/27/66 19, that (I) (we) lost saw the deceased alive on 1/27/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Carlton I Halle		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/27/66	
23C. PHYSICIAN'S NAME (Type) Carlton I Halle		23D. ADDRESS M.D. Sinai Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/28/66		24C. NAME OF CEMETERY OR CREMATORY United Hebrew Cem.	
24D. LOCATION ROSEDALE Md.		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. FEB 1 1966		25B. NAME OF REGISTRAR J. E. H. H. H.		25C. FUNERAL DIRECTOR ADDRESS TACKLE DIS INC. 2100 EATAW PL.	

1890

The first of the year was a very dry one, and the crops were much injured. The weather was very hot, and the ground was very dry. The crops were much injured, and the yield was very small.

The second of the year was a very wet one, and the crops were much injured. The weather was very cold, and the ground was very wet. The crops were much injured, and the yield was very small.

The third of the year was a very dry one, and the crops were much injured. The weather was very hot, and the ground was very dry. The crops were much injured, and the yield was very small.

The fourth of the year was a very wet one, and the crops were much injured. The weather was very cold, and the ground was very wet. The crops were much injured, and the yield was very small.

The fifth of the year was a very dry one, and the crops were much injured. The weather was very hot, and the ground was very dry. The crops were much injured, and the yield was very small.

The sixth of the year was a very wet one, and the crops were much injured. The weather was very cold, and the ground was very wet. The crops were much injured, and the yield was very small.

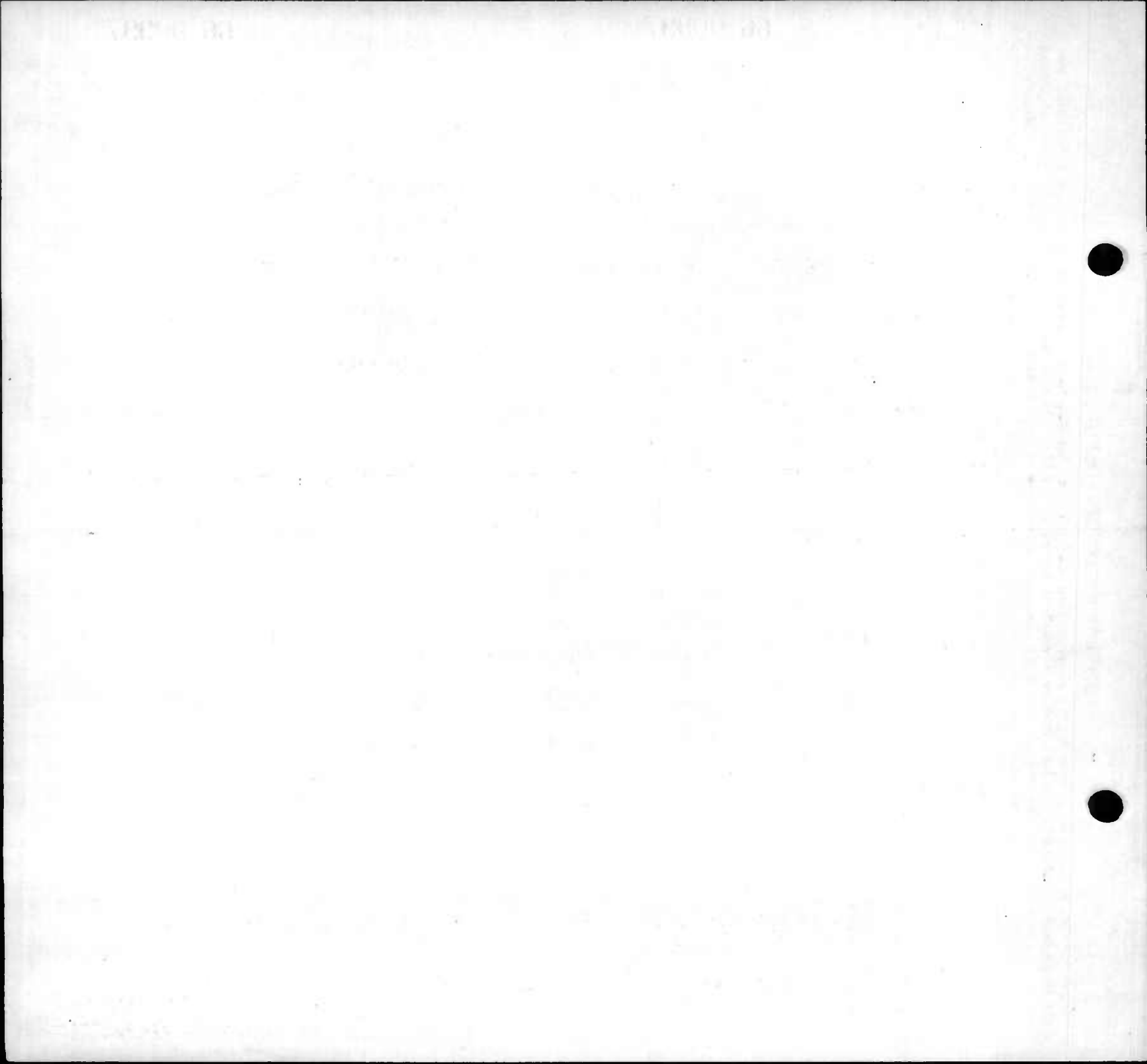
The seventh of the year was a very dry one, and the crops were much injured. The weather was very hot, and the ground was very dry. The crops were much injured, and the yield was very small.

The eighth of the year was a very wet one, and the crops were much injured. The weather was very cold, and the ground was very wet. The crops were much injured, and the yield was very small.

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00997	
66 00997				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) MARGARET MAGNESS		January 27, 1966 3 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MARYLAND B. COUNTY 20-05			
402 S. SMALLWOOD ST.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 402 S. SMALLWOOD ST.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH MAY 7 1891	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (State or foreign country) GERMANY	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME CONRAD HAHMULLER		14. MOTHER'S MAIDEN NAME KUNAKUNDA WITTMAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-24-3299		17. INFORMANT ADDRESS Charles J. Hahmuller 402 S. Smallwood St.	
18. 42011		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Ac. Coronary occlusion sudden			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Hypertensive cardiovascular disease 10 yrs			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10:22 to 1:27 19 66 , that (I) (we) lost saw the deceased alive on 1:24 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Justin Kudirka				23B. DATE SIGNED 1-28-66	
23C. PHYSICIAN'S NAME (Type) J. KUDIRKA				23D. ADDRESS 2151 Wilkens Ave	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-31-66		24C. NAME OF CEMETERY or CREMATORY ST. PAUL S LUTHERAN BALTIMORE MD	
24D. LOCATION (City, town, or county) (State) MD		25A. DATE REC'D BY HEALTH DEPT. FEB 1 1966		25B. NAME OF REGISTRAR Geo. L. Schwarz	
25C. FUNERAL DIRECTOR George H. Miller 2101 Frederick Ave.		25D. ADDRESS 2101 Frederick Ave.			



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 66 00998					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 66 00998				
1. NAME OF DECEASED (Type or Print) <i>Sweeney, Joseph</i>					2. DATE AND HOUR OF DEATH <i>1/25/66 6:50 P.M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>The Union Memorial Hospital</i>					A. STATE <i>Maryland</i> B. COUNTY <i>9-03</i>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>				
					D. STREET ADDRESS (If rural, give location) <i>3539 Greenmount</i>				
5. SEX <i>Male</i>	6. RACE <i>Caucasian</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>11/6/97</i>	9. AGE (In years last birthday) <i>68</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Handyman</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Thomas Sweeney</i>					14. MOTHER'S MAIDEN NAME <i>Anna Mae ---</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>??</i>			16. SOCIAL SECURITY NO. <i>216-14-0458</i>		17. INFORMANT <i>James Sweeney-3731 S. Hanover St.</i>				
18. <i>491X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH (A) <i>Massive aspiration pneumonia</i> DUE TO (B) _____ DUE TO (C) <i>fract</i>				
19A. DATE OF OPERATION <i>2</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (this hospital) attended the deceased from <i>January 25, 1966</i> to <i>January 25, 1966</i> , that (we) last saw the deceased alive on <i>January 25, 1966</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (view) the body after death.									
23A. SIGNATURE <i>A. C. Tipton, Jr.</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>1/25/66</i>		
23C. PHYSICIAN'S NAME (Type) <i>ANCEL C. TIPTON, JR.</i>					23D. ADDRESS <i>33rd + Calver Sts.</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-28-1966</i>		24C. NAME OF CEMETERY or CREMATORY <i>Glen Haven Memorial Park</i>		24D. LOCATION (City, town, or county) (State) <i>Ritchie Hwy., A.A. Co., Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>FEB 1 1966</i>			25B. NAME OF REGISTRAR <i>George J. Gonce</i>		25C. FUNERAL DIRECTOR <i>George J. Gonce-4001 Ritchie Hwy., Baltimore</i>				

[illegible][illegible]

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 66 00999	
CERTIFICATE OF DEATH					
BIRTH NO. 66 00999		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) BEULAH L. MCCORMICK			2. DATE AND HOUR OF DEATH Jan. 25, 1966 7:45 PM		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFIED FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3904 Pennington Ave. Baltimore 26, Md.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 25-05		
5. SEX Female			6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hair Dresser		10B. KIND OF BUSINESS OR INDUSTRY Beauty Shop		8. DATE OF BIRTH Feb. 25, 1910	
13. FATHER'S NAME Harry Cooper		14. MOTHER'S MAIDEN NAME Catherine		9. AGE (In years last birthday) 55	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 189-18-8587		12. CITIZEN OF WHAT COUNTRY? U.S.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.1 I		CAUSE OF DEATH Acute Coronary Thrombosis Coronary Insufficiency Hypertension Advanced Atherosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 10 1965 to Jan 25 1966 , that (I) (we) last saw the deceased alive on Jan 25 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (do) (did not) view the body after death.					
23A. SIGNATURE Louis J. Glass				23B. DATE SIGNED Jan. 26, 1966	
23C. PHYSICIAN'S NAME (Type) Louis J. Glass				23D. ADDRESS 320 Patapsco Ave., Baltimore 25, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-29-1966		24C. NAME OF CEMETERY or CREMATORY Meadowridge Memorial Park	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. FEB 1 1966			
25B. NAME OF REGISTRAR George J. Gonce		25C. FUNERAL DIRECTOR George J. Gonce-4001 Ritchie Hgwy., Baltimore			

letter from Dr. Glass
2-17-66- M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
66 01000					CERTIFICATE OF DEATH		Registered No. 66 01000		
BIRTH NO. 66 01000					2. DATE AND HOUR OF DEATH 1-26-66 1125 ⁰⁰ A M.				
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Stella Hill					3. PLACE OF DEATH IN BALTIMORE, MARYLAND				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital University of Maryland Baltimore, Maryland					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY HARFORD C. CITY OR TOWN (If outside city limits, write RURAL and give township) Route #1 Street 6200 D. STREET ADDRESS (If rural, give location)				
5. SEX F	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3-31-34	9. AGE (In years lost birthday) 31	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Linsey Cushatt					14. MOTHER'S MAIDEN NAME Mettles, COTTIE				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Eddie Hill Rt. #1 Street, MD.			ADDRESS	
18. I 171X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH (A) Carcinoma of cervix (B) e metastasis (C)				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Gerald Lee Points II M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 1-26-66	
23C. PHYSICIAN'S NAME (Type) Gerald Lee Points II M.D.					23D. ADDRESS University Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-29-66		24C. NAME of CEMETERY or CREMATORY WELCOME HOME		24D. LOCATION (City, town, or county) (State) BEL AIR, MD.			
25A. DATE REC'D BY HEALTH DEPT. FEB 1 1966			25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR John H. Harkins, DELTA, PA.			

